

North Carolina
Innovations
Technical Guide
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Overview and Purpose

The North Carolina Innovations Waiver is a resource for funding services and supports for people with intellectual and other related developmental disabilities that are at risk for institutional care in an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR). NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. This waiver, approved to be effective, April 1, 2008 for five years, operates concurrently with a 1915 (b) Waiver, the North Carolina Mental Health/Developmental Disabilities/ Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan). The NC MH/DD/SAS Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and developmental disabilities services are authorized for Medicaid enrollees. Local Management Entities (LMEs) are area authorities in the State of NC which are responsible for certain management and oversight activities with respect to publically funded DMH/DD/SAS services and are PIHPs for the waiver.

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

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

Purpose and Goals of NC Innovations

The NC Innovations Waiver is designed to provide an array of community based services and supports to promote choice, control and community membership. These services provide a community-based alternative to institutional care for persons who require an ICF-MR level of care and meet additional eligibility criteria for this waiver.

The Goals of the NC Innovations Waiver are:

- To value and support waiver participants to be fully functioning members of their community;
- To promote Promising Practices that result in real life outcomes for participants;
- To offer service options that will facilitate each participant'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;
- To provide the opportunity for all participants to direct their services to the extent that they choose;
- To provide educational opportunities and support to foster the development of stronger natural support networks and enable participants to be less reliant on formal support systems.

Self-Direction

NC Innovations will allow participants to play an essential role in deciding how to plan, obtain and sustain community-based services for themselves, and will help persons with disabilities live fuller, more independent lives. NC Innovations contains the framework for participants to self-direct services and supports, and offers the option for participants to choose to utilize provider agency services. Participants may choose to self-direct (participant-direct) services or may choose to have services provided through provider agencies. Participants may change models of service delivery and may opt out of self-directed services at any time.

Self-Direction (***Participant Direction***) represents a divergence from the traditional provider agency approach to service provision in that many of the responsibilities assumed by provider agencies are transferred to the individual or family. In NC Innovations, the Participant-Directed Service Option is known as ***Individual and Family Directed Supports***, which is described in this Guide. See Chapter 5 for additional information about Individual and Family Directed Supports.

The essential elements that are applied to participant-directed services are:

- Person centered planning - A process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant. (See Chapter 4)
- Individual Budgeting - The total dollar value of the services and supports, as specified in the Individual Support Plan, under the control and direction of the program participant. (See Chapter 8)
- Participant-directed services and supports - A system of activities that assist the participant to develop, implement and manage the support services identified in his/her Individual Budget. (See Chapter 5)
- Quality assurance and quality improvement (QA/QI) - The QA/QI model will build on the existing foundation, formally introduced under the CMS Quality Framework, of discovery, remediation and continuous improvement. (See Chapter 17)

CMS Waiver Requirements

CMS establishes the requirements for the administration of NC Innovations.

The waiver:

- Defines the target population and the related eligibility criteria;
- Requests the waiving of certain Medicaid requirements;
- Gives assurances regarding waiver operations, including comparing waiver costs to demonstrate cost effectiveness;
- Lists the services to be provided, including the definitions of those services and provider qualifications;
- Estimates the numbers of people to be served, service utilization, and the related costs; and
- Gives other information about program administration.

Target Population

- The waiver services are targeted to persons who meet the ICF-MR eligibility criteria defined in the Division of Medical Assistance Clinical Coverage Policy No: 8E.
- With the effective date of April 1, 2010, new participants in this waiver must live in private homes or in living arrangements with six or fewer licensed beds
- A new participant is a person who was not enrolled in the NC Innovations waiver as of April 1, 2008. Participants transitioning with their respective LME/PIHP from CAP-MR/DD to NC Innovations are not considered new participants for the purposes of waiver eligibility.
- Participants in the NC Innovations Waiver or individuals transitioning to NC Innovations may live in private homes or in the following types of facilities:

Supervised Living Type B for Children with a Primary Diagnosis of a Developmental Disability; Type C for Adults with a Primary Diagnosis of a Developmental Disability:

- Supervised Living facilities cannot exceed 6 beds except that any facility licensed on June 15, 2001, for more than 6 beds at that time are grandfathered in at no more than the facility's licensed capacity.
- To participate in the waiver, these facilities must meet home and community characteristics
- Any facility greater than six licensed beds will have no new admissions of waiver participants
- Newly developed facilities may participate in the waiver only if they are licensed for 3 beds or less

Supervised Living Type F (Alternative Family Living Serving Children or Adults with a Developmental Disability)

- Cannot exceed 3 beds
- To participate in the waiver, these facilities must meet home and community characteristics

Family Care Homes

- Cannot exceed 6 beds
- To participate in the waiver, these facilities must meet home and community characteristics
- Newly developed facilities may participate only if they are licensed for 3 beds or less

Unlicensed Alternative Family Living Homes

- Serve one adult
- Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care.

Home and community characteristics are defined in Chapter 13.

Subject to funding availability and program requirements, a person with mental retardation (intellectual disability) or related developmental disability who meets the criteria in Appendix E may be considered for NC Innovations funding.

Waived Medicaid Requirements

The following requirements are waived in the NC Innovations Waiver:

- **Statewidelessness:** The Social Security Act requires Medicaid services to be provided on a statewide basis. This requirement is waived to limit NC Innovations Waiver participants to legal residents (for the purpose of Medicaid eligibility) of the PIHP Regions.
- **Comparable Services:** The Act requires a state to provide comparable services in amount, duration, and scope to all Medicaid recipients. This requirement is waived to allow NC Innovations Waiver Services to be offered only to individuals participating in the NC Innovations Waiver.
- **Deeming of Income and Resources:** Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This is "deeming" income and resources to the Medicaid recipient. The deeming requirement is waived to allow Medicaid eligibility for NC Innovations Waiver participants to be considered similar to the methods used for people who are residing in ICF-MR group homes or the State Developmental Centers.

Waiver Assurances

A state must provide various assurances to CMS to obtain a Waiver. The North Carolina Division of Medical Assistance has provided assurances regarding the following:

- **Health and Welfare of Recipients:** Necessary safeguards are taken to protect the health and welfare of recipients. These safeguards include provider qualifications, criminal background checks, certification/licensure requirements, individual risk assessment, planning for emergency back-up staffing and/or emergency response capability, incident reporting, and other requirements related to the health, safety, and well-being of the participants.
- **Financial Accountability:** There is financial accountability for funds expended for NC Innovations services. The PIHP in conjunction with the Division of Medical Assistance will maintain and make available to the Department of Health and Human Services, the Comptroller General or other designees appropriate financial records documenting the cost of services provided under the Waiver.
- **Evaluation of Need:** There is an initial evaluation and annual reevaluations of the need for ICF-MR care. Written documentation of evaluations is maintained.
- **Choice of Alternatives:** When a participant is determined likely to require the level of care provided in an ICF-MR facility, the participant or the participant's legal representative will be informed of any feasible alternatives available under the waiver and given the choice of either institutional or NC Innovations services.
- **Average Per Capita Expenditures:** 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 of care specified for this waiver had the waiver not been granted.
- **Actual Total Expenditures:** The actual total expenditures for home and community based waiver services and other Medicaid services and its claim for Federal Financial Participation (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 have been incurred in the absence of the

waiver by the States Medicaid program for these individuals in the institutional setting(s) specified in this waiver.

- **Institutionalization Absent the Waiver:** Absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid funded institutional care for the level of care specified in the waiver.
- **Reporting:** North Carolina will provide annual reports to CMS about the impact of the waiver on the type, amount, and cost of services provided under the State Plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by CMS.
- **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 education agency under the IDEA Act of 2004 or the Rehabilitation Act of 1973; and
 2. Furnished as part of expanded habilitation services.

Services and Provider Qualifications

The services that are included in the NC Innovations Waiver are listed in Appendix C. The service definitions and provider qualifications for each service are listed in Chapter 13.

Number of Participants

The number of individuals is an unduplicated count of individuals served during a Waiver year. The waiver year is April through the following March. The projection anticipates that individuals will leave the program and others will join the program during the year. A person is counted against the annual allotment once the individual is entered into the Medicaid eligibility system as a NC Innovations participant. The person continues to count as one participant if he or she leaves and re-enters the program during the same Waiver year. The NC Innovations Waiver reserves a portion of the participant capacity to transition individuals from CAP- MR/DD (the 1915 (c) MR/DD waiver that serves the remainder of the state), from NC Innovations, Military Transfers, Money Follows the Person, Community Transition for institutionalized children aged 17 and younger and when aging out of the CAP C waiver.

Waiver capacity is managed on a statewide basis. DMA allocates Slots and Reserved Capacity Slots to each PIHP, with the exception of Military Transfers. See Chapter 7 for additional information about the management of Reserved Capacity Slots.

Administration

The Prepaid Inpatient Health Plan (PIHP) manages the local operations of the waiver with oversight provided by the Division of Medical Assistance (DMA). DMA is a division within the Department of Health and Human Services (DHHS). DMA will retain the responsibilities of approving all policies, rules and regulations concerning this waiver and will assure accountability and effective management of the waiver. DMA remits to the PIHP a monthly capitated payment for each individual enrolled in the NC Innovations Waiver. The PIHP will ensure that claims for services rendered are paid only for those services authorized in the Individual Support Plan. As services are delivered and providers file claims, the PIHP will reimburse them as agreed upon in their individual contract, within prompt pay requirements.

The PIHP provides treatment planning case management (care coordination) for NC Innovations participants under this program. A case manager, referred to as a Care Coordinator, provides these services. The PIHP arranges for waiver services to be provided through contracted service providers. Individuals may also choose to self-direct services. The PIHP will provide information to the participant about:

- The person centered planning process and the development of the Individual Support Plan including the re-assessment schedule;
- Individual choices, including freedom of choice of providers within the PIHP Network;
- The process for developing/changing the Individual Budget;
- Individual rights; and
- The Medicaid Appeals Process.

Note: The PIHP may opt to contract out their assessment and treatment plan development. All other care coordination functions must be provided by the PIHP.

Chapter 17 describes the NC Innovations Quality Assurance and Improvement Program, including the state procedures for monitoring and oversight of the NC Innovations Waiver. CMS monitors the waiver operation through annual reports submitted by the State and on-site reviews. DMA prepares and submits the required Federal reports and shares the reports with the Intradepartmental monitoring team, which includes DMH/DD/SAS. The annual reports include information on the number served, service utilization, costs and health/welfare issues.

Coordination with Other Medicaid Services

NC Innovations operates concurrently with the North Carolina Mental Health/ Developmental Disabilities/ Substance Abuse Services Health plan (NC MH/DD/SAS Health Plan). See Chapter 2 for additional information about the operations of NC Innovations with the NC MH/DD/SAS Health Plan. The NC MH/DD/SAS Health Plan includes State Medicaid Plan services for behavioral health services as well as inpatient psychiatric and Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Approval of the NC Innovations Individual Support Plan does NOT replace the prior approval requirements or other eligibility requirements for services in the State Medicaid Plan, which are outside of the NC MH/DD/SAS Health Plan, i.e. Private Duty Nursing, PT, OT, Speech Therapy, etc. These services are not part of the NC Innovations Waiver or NC MH/DD/SAS Health Plan and are accessed through the regular State Medicaid Program.

Waiver Funding and Prioritization for Funding

Waiver funding is made available to the number of people specified in the approved waiver. Additional people may only be served if the North Carolina General Assembly provides more funding, and CMS approves a request to serve additional people. The waiver also specifies funding that is set aside for military transfers, Money Follows the Person; Community Transition for Institutionalized Children, people with emergency needs and people who are transferring from the State Waiver, the Community Alternatives Program for People with Intellectual/Developmental Disabilities (CAP-MR/DD) and individuals who are aging out of (CAP-C). Setting aside funding with a waiver is referred to as “Reserved Capacity”.

Individuals, who do not access NC Innovations through the reserved capacity slot process, access the waiver based on their date of referral (first come first served basis). Funding is distributed on a per capita basis, geographically among the subdivisions of the PIHP areas (counties). Within the subdivisions, the waiver funding is distributed by date of referral. See Section 7 for additional information about Prioritization for Funding, Criteria for Reserved Capacity Funding, the geographical distribution of slots, and the Registry of Unmet Needs.

Transition of CAP-MR/DD Residential Providers to NC Innovations

All CAP-MR/DD waiver residential providers in the PIHPs' areas will be accepted into the new PIHP network if they meet the following criteria:

- Maintain home and community character and meet all other waiver requirements defined in Appendix C:2
- Currently provide Residential Supports under the CAP-MR/DD waiver (excludes Adult Care Homes providing Residential Supports)
- Are qualified under the PIHP network which ensures that they meet the service specific provider qualifications and
- Choose to join the PIHP network

North Carolina Innovations and the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan

North Carolina Innovations operates concurrently with the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan, a 1915 (b) waiver that provides for the delivery of all mental health, developmental disabilities and substance abuse services, including NC Innovations Waiver services, to Medicaid beneficiaries in the service area. The PIHP functions as the single Prepaid Inpatient Health Plan (PIHP) for the concurrent waivers.

Role and Responsibility as a Prepaid Inpatient Health Plan (PIHP)

All Medicaid MH/DD/SA services, including NC Innovations services, are authorized by and provided through, the PIHP in accordance with the risk contract between the Division of Medical Assistance and the PIHP. The PIHP is paid a capitated per member, per month fee to conduct all utilization management/prior approval activities, level of care determinations, provider network credentialing, and enrollment/provider reimbursement. As a prepaid inpatient health plan, the PIHP will be at financial risk for a discrete set of Mental Health, Developmental Disabilities and Substance Abuse services, including both Medicaid State Plan services and services contained in the NC Innovations Waiver.

Relationship between the NC MH/DD/SAS Health Plan and the NC Innovations Waiver

Individuals who participate in the NC Innovations 1915 (c) Waiver are additionally enrolled in the 1915 (b) NC MH/DD/SAS Health Plan. The PIHP receives a monthly capitation payment from the state Medicaid agency, DMA, for each participant that includes an amount for participation in the NC MH/DD/SAS Waiver and an amount for participation in the NC Innovations Waiver. The PIHP contracts with providers of Waiver Services and pays providers for the provision of those services from the monthly payment from DMA. Should individuals participating in the NC Innovations Waiver have a need for state plan mental health and/or substance abuse services or optional (b) (3) services, these needs will be met through services provided through the NC MH/DD/SAS Health Plan. Medical needs are met through the State Medicaid plan.

Free Choice of Providers

Participants will have free choice of providers within the PIHP network and may change providers as often as desired. If an individual's Medicaid changes to one of the counties within the PIHP and is already established with a provider who is not a member of the network, the PIHP makes every effort to expedite the entrance of the provider into the network. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if a participant needs a specialized Medicaid service that is not available through the network, The PIHP arranges for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, participants are given the choice between at least two providers. Exceptions would involve institutional services or highly specialized services that are usually available through only one facility or agency in the geographic area.

Assessment of Needs

The assessment process determines the feasibility of NC Innovations participation and the need for continued participation. The assessment process considers the services and supports needed to enable the person to attain an optimal level of independence and self-sufficiency. It addresses the well-being of the person, including risks in the person's life that need to be addressed to ensure the person's health and welfare in the community. The process determines the person's abilities; the help the person needs; the support available from and needed by informal caregivers; the help available from other sources; the person's living situation; and the individual's/responsible party's preferences in regard to care and the best strategy to meet the Life Goals of the person. The assessment process, reflecting a person-centered approach, is the basis for the Individual Support Plan (ISP).

Assessments include evaluations applicable to the person's situation that are required to determine the person's needs related to their mental retardation (intellectual disability) or related developmental disability, to live inclusively in their community with maximum independence. Assessments should focus on the person's strengths, abilities and positive steps used to enhance the person's ability to meet his or her Life Goals, or to help the person determine what Life Goals to pursue. Assessments should also show the barriers to a person's attainment of his/her Life Goals and be a foundation for determining how to address the barriers.

Level of Care

The initial Level of Care evaluation is required to determine that the person meets the ICF-MR eligibility criteria required to receive NC Innovations waiver services. This assessment is completed when the person initially enters the waiver or if there is any question regarding continued eligibility. This assessment documents a diagnosis of mental retardation (intellectual disability) or a condition closely related to mental retardation and measures the person's severity of disability. The assessment will be based on information gained from a psychological evaluation and an adaptive behavior assessment.

Supports Intensity Scale

To strengthen the Person Centered Planning Process, participants who receive NC Innovations Wavier services will receive a Supports Intensity Scale (SIS ®) assessment. This is a nationally recognized assessment that measures the level of supports required by people with disabilities to lead normal, independent, quality lives in their home community. It covers general, medical and behavioral areas, including home living, community living, lifelong learning, employment, health and wellness, social activities, protection and advocacy, as well as medical and behavioral support needs. All of these supports are rated for frequency (how often support is needed), daily support time (how many hours of support is needed) and type of support (verbal, gesturing, physical assistance, etc.). Rather than determining what is wrong or deficient, as conventional assessments do, the SIS ® helps determine what kind, amount and intensity of supports are needed for someone to succeed in the important areas of his or her life. This assessment is completed at the time an individual enters the waiver and no less than every 2 years, or as significant changes occur for the participant to assist the planning team to ensure that, the right amount and intensity of service/support are available for the participant. This information is required to support the need for additional services.

Once implemented, NC Innovations applicants and participants are required to participate in the Supports Intensity Scale. The Supports Intensity Scale is administered by an American Association of Intellectual Disabilities (AAIDD) trained interviewer. A Care Coordinator or a Care Manager may not administer the SIS ®.

North Carolina Support Needs Assessment Profile (NC-SNAP)

The NC-SNAP is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for developmental disabilities (DD) supports and services. The NC-SNAP was officially adopted by the State of North Carolina in 1999 as the requisite tool for determining an individual's intensity of need for DD services. The NC-SNAP assesses level of intensity of need in the areas of Daily Living Supports, Health Care Supports, and Behavioral Supports. The NC-SNAP will be utilized, annually, until the SIS ® is operationalized. The PIHP determines the staff that administers the NC-SNAP. This may be the Care Coordinator or other designated staff.

Risk/Support Needs Assessment

During the information gathering phase of the Individual Support Plan, a Risk/Support Needs Assessment is completed by the participant's Care Coordinator. The Care Coordinator provides information about Risk/Support Needs Assessment and makes sure these risks/needs are addressed in the Individual Support Plan. Potential risks and safety considerations can include health, medical and/or behavioral areas of concern.

Medical Evaluation

The Care Coordinator will obtain additional medical information regarding the participant's medical condition and will arrange for medical evaluations, and/or medical care. The Care Coordinator asks for additional medical information and/or makes sure that the ISP has strategies for obtaining additional medical evaluation information before submitting the ISP for approval by the PIHP. The Care Coordinator coordinates with the participant's CCNC medical home.

Other Evaluations/Assessments

Recommendations from assessments are an important component of the development of the ISP. If during the development of the ISP other needed assessments are required they are obtained, or a plan for obtaining those must be included in the ISP. During the assessment process, the Care Coordinator works with the participant, family and the planning team to identify supports that the participant is already receiving, both formal and informal including private insurance.

Assessments and evaluations are completed based on the participant's situation and needs. These may include educational, vocational, physical therapy, occupational therapy, speech, hearing, dietary, psychiatric, behavioral, and other applicable evaluations conducted by qualified individuals. Evaluations must reflect the participant's current situation. An evaluation is "current" when it describes the person's situation at the time it is included in the assessment package. If the conditions and/or functioning of the participant have changed since the assessment, the assessments are not current and new assessments are obtained. This is an on-going process coordinated by the Care Coordinator.

Annual Review of Waiver Recipients

The ISP annually reassesses the participant's need for NC Innovations waiver services by the completion of an Annual ISP. The Annual ISP is completed during the birth

month of the person. See Chapter 10 for a description of the Annual ISP process. The Care Coordinator is responsible for coordinating the evaluations, planning teams, and other information required for plan development. This should be done in a timely and cost-effective manner. The Risk/Support Needs assessment is completed during the development of the Annual ISP. The most current SIS ® is used. Until the SIS ® is phased in, the NC SNAP is used. Other assessments will be completed as clinically appropriate to ensure current/accurate assessment information. Until the Supports Intensity Scale is fully implemented, PIHP's will administer the NC SNAP.

Documentation

Each evaluation must be signed and dated by the individual completing the evaluation, and must include the credentials of the evaluator. A copy of each evaluation used in the assessment process is kept in the participant's record. Copies of evaluations used to support the clinical necessity for services will be included with the ISP when authorization is requested.

Individual Support Planning

The Individual Support Plan (ISP) is developed through a person centered planning process and is led by the participant and/or legally responsible person for the participant to the extent they desire. Person-centered planning focuses on supporting participants to realize their own vision for their lives. It is a process of building effective and collaborative partnerships with participants, and working with them to create a road map for the ISP to reach the participant's goals. The planning process is directed by the participant and identifies strengths and capabilities, desires and support needs. A good person-centered plan is a rich meaningful tool for the participant receiving supports as well as for those who provide the supports. It generates actions—positive steps that the participant can take towards realizing a better, more complete life. Good plans ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to access the quality of services being provided.

Transition for Individuals from the CAP-MR/DD Waivers to NC Innovations

As new PIHPs and counties are added, the transition will be seamless for individuals transitioning from the CAP-MR/DD Comprehensive and Supports waivers services to the extent that CAP waiver providers are enrolled in the new PIHP networks. To ensure a smooth transition:

- The waiver eligibility determination by the CAP-MR/DD program will be accepted in the NC Innovations waiver until the next annual re-evaluation of eligibility in the individual's birth month. The annual re-evaluation requires a review by the Care Coordinator and is documented in the ISP. The Care Coordinator refers the participant to the PIHP for the full evaluation process if continued ICF-MR level of care eligibility is questioned. The full evaluation process is not repeated if the Care Coordinator documents that the Level of Care continues to be ICF-MR.
- The CAP-MR/DD person centered plan will be accepted in the NC Innovations waiver until the next annual individual service plan (ISP) is developed in the individual's birth month. The participant's ISP will continue to be reviewed as needed due to changes in care needs and on an annual basis. If needed an ISP Update will be completed.
- CAP-MR/DD Services will be cross walked to NC Innovations services and included in the updated Person Centered Plan. The NC Innovations waiver includes services that crosswalk to the CAP-MR/DD waiver.
- The amount of total of the services from the CAP-MR/DD Waiver will serve as the prospective Individual Budget at the time of transition and be recorded as base or Add On Services

Role of the Care Coordinator

Care Coordinators who qualify as a Qualified Professional (QP) under North Carolina's credentialing system (NC G.S.-122 C) and who are competent in various models of Person Centered Planning, guide the planning process. The Care Coordinator is responsible for the preparation of the Individual Support Plan. The Provider Agency, Employer of Record and Agency with Choice are responsible for the development/writing of the short-range goals and strategies to reach long range outcomes. Guidance for the ISP and planning process is located in The NC Innovations Individual Support Plan System Manual.

Entities and/or individuals, including those entities and individuals under contract with the PIHP to provide care coordination services to NC Innovations participants may not provide other direct waiver services to the participant. When employed by the PIHP, Care Coordinators developing plans are employed in a separate unit from individuals authorizing the plan. The Care Coordinator may not exercise prior authorization authority over the Individual Support Plan.

Participant Authority and Composition of the Planning Team

At the time the participant enters the waiver, written information on the NC Innovations Waiver, will be given to the participant/family. This information is developed by the PIHP and contains eligibility requirements, service definitions, Individual Budgeting information, and information about the planning process. The participant's Care Coordinator is available to answer any questions the participant/family may have regarding available services. The Care Coordinator works with the participant to develop the ISP. The Care Coordinator determines with the participant and/or legally responsible person the degree to which they desire to lead the planning team and to identify its membership. If there are sensitive topics that the participant does not want discussed in an open setting, the participant (or parents/legally responsible person) and the Care Coordinator agree as to how these will be handled and with whom they will be discussed. In addition to the participant, parents, legally responsible persons and Care Coordinator, additional planning team members may include: service providers (including the Community Guide), family, friends, acquaintances, and other community supporters.

Individual Support Plan Process and Meeting

The planning process begins with an assessment of the appropriateness of the participant's current services/placement in light of their needs and preferences. A variety of assessments are completed to support the planning process as described in Chapter 3. Prior to the Individual Support Planning Meeting, the Care Coordinator offers the participant/legally responsible person the opportunity to receive an *Orientation to the Individual and Family Directed Supports Option*. Orientation materials are developed by each PIHP. The Care Coordinator also informs the participant/legally responsible person of the participant's Individual Budget amount and answers any questions regarding the Budget.

The Care Coordinator assists the participant in scheduling the meeting and inviting team members to the meeting at a time and location that is desired by the participant. Each team member receives a written invitation to the meeting. The participant and Care Coordinator review with the team all issues that were identified during the assessment processes. Information is organized in a way that allows the participant 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 participant's services, supports, and health/safety issues. During the planning meeting decisions are made regarding team member responsibilities for service implementation and monitoring. While the Care Coordinator is responsible for overall monitoring of the ISP and the participant's situation, other team members, including the participant and family and other members of the community who support the participant, may be assigned monitoring responsibilities.

Based on decisions made during the ISP meeting, the Care Coordinator documents the results of the planning meeting on the Individual Support Plan form. The ISP includes formal and informal services and supports that the participant wants and/or needs. The participant or legally responsible person participates in the documentation of the results of the meeting to the degree that they desire. The ISP also provides for supports and coordination for the participant to access school based services, generic community resources and Medicaid state plan services.

The Care Coordinator is responsible for the development of Long range outcomes with the planning team. Long-range outcomes are broad in nature, address life areas, relate to issues identified, and address needs gathered in the assessment process. Providers/Agencies With Choice/Employers of Record are responsible for the development of the short-range outcomes identified in the individual's support plan with the participant/legally responsible person. Short-range goals are steps taken to achieve the long-range outcome. Short-range goals are statements describing a proposed behavior, or what the individual will do. Short-range goals are based on wants/needs of the individual. Short-range goals should make sense to support the individual to live a successful life. Short-range goals are based on the individual's preference or need, not for staff convenience or preference.

The Individual Support Plan Manual provides complete instructions for completion of each part of the ISP. A copy of the Individual Support Plan is located in Appendix G.

Back-Up Staffing Plan

A Back-Up Staffing Plan is included in the ISP and is designed to meet the needs of the participant to ensure that if the assigned staff person is unable to provide the service, another qualified person is available when the absence presents a health and welfare risk to the participant. Each Planning Team designs an effective back-up staffing plan that is designed to meet the unique needs of the individual. Back-up Staff is needed when:

- The staff person quits unexpectedly
- There is need for the provider agency, Agency With Choice or Employer of Record to release the staff person (terminate the employment of the staff person)
- The staff person is sick or on extended leave
- The staff person is on vacation

The Back-Up Staffing Plan is included in the Individual Support Plan and clearly identifies:

- What service the back-up staffing is intended to provide
- The back-up staffing individual or agency
- Who to call if there are unmet emergency staffing needs or the back-up staffing plans are not working.
- The type of back-up arrangements, for example provider agency staff or unpaid supports. Please note that the provider agency is responsible for providing back-up staffing if the family chooses this as the back-up plan.

Failure to provide Back-Up Staffing is a level one incident and is documented on the PIHP Back-Up Staffing Incident Reporting Form. See Chapter 17 for information about

Incident Reporting, and Appendix S for the form. The Care Coordinator will complete monitoring of the Back-Up Staffing Plan implementation during their routine monitoring of services.

Management of Risks

Support needs and potential risks that are identified during the assessment process are addressed in the ISP. Strategies to mitigate risks reflect participant needs and include consideration of the participant preference. Strategies to mitigate risks may include the use of risk agreements/behavioral contracts. The ISP also states how risks will be monitored, including the paid providers, natural and community supports, participants, their families, and/or the Care Coordinator. DMH/DD/SAS Rule 10A NCAC 27E.0107 that addresses Training on Alternatives to Restrictive Interventions must be followed, if applicable.

Approval of the Initial Individual Support Plan

The completed Initial ISP, signed by the participant/legally responsible person, Care Coordinator, and QP, is submitted to the PIHP for approval, no later than 60 days from the effective date of the Level of Care. See Chapter 10 for a full description of this process. All initial/annual plans, and plan updates require an authorized signature(s).

The ISP approval process includes the use of a standardized checklist, and verifies that there is a proper match between the participant's needs and the services provided, provided health and welfare is maintained and all areas of waiver compliance maintained. See Appendix L for the Minimum Elements for Innovations ISP Approval Checklists. Once the ISP is approved and services are authorized, the Care Coordinator notifies the participant/legally responsible person of the approval, the services that will be provided, and the start date of services. The participant/legally responsible person is given a copy of the approved ISP and Individual Budget, including Crisis Plan as applicable.

Choosing a Provider of Services

Information and support is available to assist participants to freely choose among network providers. The Care Coordinator provides information to participants about their rights, protections, and responsibilities, including the right to change providers. The Care Coordinator assists the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP to the degree the participant/legally responsible person desires. The Care Coordinator meets with the participant/legally responsible person and provides them with a listing of each qualified provider within the PIHP provider network and encourages them to select providers that they would like to meet to obtain further information. The Care Coordinator provides any additional information that may be helpful in assisting them to choose a provider. Arranging provider interviews is facilitated by the Care Coordinator on behalf of the participant to the degree the participant/legally responsible person desires. Once the participant has selected a provider, their choice of provider is documented in the service record.

The participant/legally responsible person may elect the Individual and Family Directed Supports Option instead of services provided by a provider agency. If selected, the Care Coordinator arranges for a Community Guide to train the participant in Individual and Family Directed Supports. All services and supports are provided in accordance with the participant's plan.

Annual Plans and Updates/Changes to Plans

Annual Plans are developed to be effective the first day of the month following the participant's birth month. The Care Coordinator works with the participant and the team to ensure that the ISP and subsequent Annual ISP's are 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. Chapter 10 contains information about updating the ISP.

Individual and Family Directed Supports Option

The NC Innovations Waiver gives people with disabilities clear choice about how they receive services. Participant Direction is a meaningful option for participants as well as their families. In the NC Innovations Waiver, Participant Directed Services are called Individual and Family Directed Supports. Participants can direct some or all of the services that are paid through NC Innovations funding. This gives participants and families more control over the way their services are provided, including the authority to manage an Individual Budget and employee/manage workers who provide support. Appendix C lists services that may be participant directed in the NC Innovations Waiver.

The models of Participant Direction described in this Guide are included in the CMS approved North Carolina Innovations waiver. No other model of Participant Directed Services may be offered to an individual in the North Carolina Innovations waiver. All Agencies With Choice must be approved by the PIHP. NC Innovations Services may only cover the services defined in the waiver and may only be used to provide services, supports, equipment and supplies in the service definitions approved by CMS. Provider Agencies may not offer the participant an expectation of “savings” to use for equipment, supplies or any other incentive or an offer of a co-employment arrangement as a condition of provision of services to that participant. Supervision of services must always be provided as written in the provider qualifications of the service definition.

Principles of Self-Determination

The Individual and Family Directed Supports Option is based on the principles of Self-Determination. Self-Determination empowers individuals to gain control over selecting the services or supports that meet their unique needs. It is a process that varies from person to person according to what each individual feels is necessary and desirable to create a satisfying and personally meaningful life. It is both person-centered and person-directed.

The Principles of Self-Determination are:

- Freedom – The ability of an individual, together with freely chosen family and friends, to plan a life with necessary supports rather than purchase or conform to a set program.
- Authority – The ability of a person with a disability (with a social support network or circle if needed) to control a certain sum of money in order to purchase services.
- Autonomy – The arranging of resources and personnel -- both formal and informal -- to assist an individual with a disability to live a life in the community rich in personal and community affiliations.
- Responsibility – The recognition of a person’s valued role in the community through competitive employment, organizational affiliations, spiritual development, and general caring of others in the community as well as accountability for spending public dollars in ways that are life-enhancing for persons with disabilities.
- Confirmation – The recognition of the importance of the leadership of self-advocates in the Self-Determination movement.

(From the work of Nerney, T. and Shumway, D.)

Advantages of Individual and Family Directed Supports

Participant Directed Services have been successfully implemented in Home and Community Based Waivers in a number of states, including North Carolina. A number of advantages have been reported for participants including:

- Increased independence and self-sufficiency
- Increased choice, flexibility, and control of services
- Improved quality of services
- Increased opportunities for a more healthy and productive life with better personal outcomes
- Increased satisfaction with services
- Increased use of people that the participant knows as employees
- Expanded information to assist in decisions around spending of resources
- Focused assistance to make participant direction possible
- Authority to hire, train, supervise, and, if necessary, fire employees
- Increased partnership between participants and professionals
- Increased meaningful relationships in the community

Models of Individual and Family Directed Supports

Two Models of Individual and Family Directed Supports are available:

- The Employer of Record Model allows the participant or the legally responsible person for the participant to be the individual who legally can exercise authority over workers and assume the other responsibilities associated with participant direction of services. The participant or the legally responsible person is known as the Employer of Record.
- The Agency With Choice Model allows the participant or legally responsible person for the participant to work with an agency that agrees to hire employees referred by them. The agency approves/disapproves the hiring of the referred individuals and ultimately retains the responsibility of being the employer while allowing the participant or legally responsible person to partner in managing the employee's training and supervision. The participant or the legally responsible is known as the Managing Employer.

Both models of Individual and Family Directed Supports are available in the PBH area, including PBH expansion counties. In the other PIHPs, the Agency With Choice Model will initially be available. The Employer of Record Model will be available in the other PIHPs no later than two years from the date of transition to NC Innovations. PIHPs may present a plan to implement the Employer of Record model earlier by submitting an implementation plan and the results of a readiness review of at least one contracted Financial Support Agency. The implementation plan must include all required NC Innovations Individual and Family Directed Supports documents and a plan that demonstrates that contracted Community Guide Agencies have or will be trained in the Employer of Record Model by the proposed implementation date. DMA will approve implementation plans prior to the implementation date. The Intra Departmental Monitoring Team will provide oversight in the implementation of Individual and Family Directed Supports.

While this Chapter contains information about both Models of Individual and Family Directed Supports, the information about the Employer of Record Model

only applies to PIHPs providing the Employer of Record Model as described in the previous paragraph.

Participant/Legally Responsible Person Decisions

The Participant/Legally Responsible Person:

- chooses to participate in Individual and Family Directed Supports or chooses to receive their services from a Provider Agency
- chooses the model of Individual and Family Directed Supports under which services will be directed, Agency With Choice or Employer of Record (when both models are available in the PIHP area). Until both models of Individual and Family Directed Supports are available, the participant may elect to participate in the Agency With Choice Model.
- An Employer may change models or return to Provider Directed Services at any time by notifying the Care Coordinator.

The participant may choose to direct one or more services, and may receive additional provider directed services that the participant does not choose to self-direct. Services that may be Participant Directed are:

- Community Guide Services
- Community Networking Services
- In-Home Intensive Supports
- In-Home Skill Building
- Individual Goods and Services
- Natural Support Education
- Personal Care Services
- Respite Services
- Supported Employment Services

General Requirement for all Parties in Individual and Families Directed Supports

Any party involved in Individual and Family Directed Supports, including Employers, Representatives, Agencies With Choice, Provider Agencies, Financial Support Agencies and employees shall not have been excluded from or suspended from participation in the Medicare or Medicaid Programs. These parties shall not have been convicted of Medicare or Medicaid fraud.

People or Agencies that Provide Assistance with Individual and Family Directed Supports

It takes time for participants and their families to feel confident about directing their own services. The PIHP is committed to helping them acquire the skills needed to direct services, and to handle the responsibilities that come with participant direction. This assistance includes:

- Orientation, Information, and Training on Individual and Family Directed Supports
- Financial Support Services (required for individuals who elect the Employer of Record Model)
- Agencies With Choice (required for individuals who elect the Agency With Choice Model)
- Community Guide Services (based on needs and preferences; required for initial training of Individual and Family Directed Supports). An individual or family

member may also need the assistance of a Representative to assist in directing services. A Representative may be elected or may be required

- **Care Coordinator**

Care Coordination is provided to Individuals who participate in the Individual and Family Directed Supports Option. Responsibilities of the Care Coordinator include:

- Provides an Orientation to Individual and Family Directed Supports
- Refers the Individual to a Community Guide Agency for Training on Individual and Family Directed Supports
- Completes the Individual and Family Directed Supports Assessment
- Completes the Process for Appointment of a Representative, when one is requested or needed
- Completes the Individual and Family Directed Supports Agreement. The Agreement is developed by the PIHP and contains the minimum elements listed in Appendix R.
- Provides any assistance needed to the prospective Employer in selecting a Financial Support or an Agency With Choice from the list of designated Agencies With Choice contracted with the PIHP
- Completes an ISP or Update(s) to the ISP
- Sends a copy of the approved ISP or Update to the ISP to the Community Guide, Employer and Agency With Choice, if applicable.

- **Financial Support Agency**

Financial Support Services are utilized by Employers of Record for paying employees, and ensuring that other fiscal functions are completed. Financial Support Services are a required service for participants who choose the Employer of Record Model of Individual and Family Directed Supports. Additional information about Financial Support Services and the assistance provided by Financial Support Agencies is found later in this Chapter.

- **Agency With Choice**

Agencies With Choice are provider agencies who meet the qualifications for service delivery of all NC Innovations Service that may be directed under the Individual and Family Directed Supports Option and that are designated by the PIHP as Agencies With Choice. Agencies With Choice perform the financial support functions for Managing Employers who choose the Agency With Choice Model. The Agency With Choice serves as the common law employer with federal and state agencies for employees hired to provide services to participants. Additional information the assistance provided by Agencies With Choice is found later in this Chapter.

- **Community Guide**

Community Guide Services assist participants in locating and coordinating community resources and activities as well as facilitating the integration of the individual in the community. These services support participants, representatives, and Employers who direct their services by providing direct assistance in their participant direction responsibilities. Community Guide Services are intermittent and fade as community connections develop and skills

increase in participant direction. A formal fading plan is not required. Community Guides assist and support (rather than direct and manage) the participant throughout the service delivery process. See Chapter 13 of this Guide for additional information about Community Guide Services, including the specific functions of the Community Guide.

The Participant, Employer and/or Representative are the primary contacts for the Community Guide. The specific functions that the Guide will perform are specified in the ISP and authorized by the PIHP. The services provided by the Community Guide are billed to the NC Innovations waiver as an “Add-On” to the Individual Budget. Community Guide Services differ from and do not duplicate treatment planning case management that is performed by the Care Coordinator. Based on the Community Guide needs identified in the ISP, the Community Guide, with the participant and legally responsible person, develops short term goals and strategies to meet the identified long range outcomes documented in the ISP to meet those needs.

The Community Guide gives the Employer and Representative, if applicable, the important phone numbers and addresses that are needed, including back-up contact information should the assigned Community Guide be unavailable. It is the responsibility of the Employer or representative, if applicable, to contact the Community Guide if there are questions or problems with directing services. It is also their responsibility to contact the Care Coordinator if Community Guide needs to be changed or additional Community Guide Services are needed. As experience is gained in directing services, the need for Community Guide services related to participant direction activities should decrease.

- ***Representative***

In the Individual and Family Directed Supports Option, the adult waiver participant, parent(s) of the minor participant or legal guardian is designated as the Employer. The Employer is assessed to determine if help is needed to manage supports. If help is needed, a person will be named to provide this assistance. This person is known as a Mandated Representative. If one is not required, a Managing Employer may still ask that a Voluntary Representative be appointed. 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.

The Representative must meet the following requirements:

- Demonstrate knowledge and understanding of the participant’s needs and preferences and respect those preferences. Show evidence of a personal commitment to the participant and be willing to follow the individual’s wishes while using sound judgment to act on the participant’s behalf
- Agree to a predetermined level of contact with the participant
- Be at least 18 years of age
- Be willing and able to comply with program requirements
- Be approved by the participant or his/her legal representative to act in this capacity

The Representative may not:

- Be paid for being the representative
- Provide paid services to the participant, including employees of agencies providing services, with the exception of guardianship services
- Have a history of physical, mental, or financial abuse

The responsibilities of the Representative are outlined in the Representative Agreement that the Representative and Employer sign prior to the appointment of the Representative. See Appendix R for a copy of this Agreement, and forms used in the Appointment of a Representative.

A Representative is required if the Employer is assessed to need help with:

- Understanding and making decisions about the participant's care needs
- Organizing the participant's life and environment, as needed
- Understanding how to recruit, hire, train, and supervise employees
- Understanding the impact of decisions on the life of the participant

When circumstances indicate that there has been a change of competency or ability to self-direct as demonstrated by non-compliance with program objectives, it may also be necessary to appoint a Representative. If needed, the following procedures are used to establish a Representative:

- The Care Coordinator assists the prospective Employer in identifying a person to serve as the Representative.
- The Care Coordinator presents the Orientation to Individual and Family Directed Supports as well as a Representative Description to the prospective Representative. The Representative Description is located in Appendix R.
- The Care Coordinator provides or arranges for written information about the NC Innovations Waiver to be given to the prospective Representative.
- The Care Coordinator refers the Prospective Representative to the Community Guide for training, making sure that there is sufficient Community Guide Services in the participant's ISP. Whenever possible, the Managing Employer and Representative should be trained together. Training is required prior to the completion of the Representative Assessment. Training curriculum and materials are developed by the PIHP.
- The Community Guide provides the Individual and Family Directed Supports Training to the Prospective Representative as well as other resource materials.
- Following completion of training, the Care Coordinator completes the Representative Screening Questionnaire and Individual and Family Directed Supports Assessment. See Appendix R for the Representative Screening Questionnaire. The individual and Family Directed Supports Assessment is developed by the PIHP and contains the minimum elements listed in Appendix R.
- If the potential Representative agrees to serve, the Designation of Authorized Representative Form and Representative Agreement are

signed and witnessed. See Appendix R for a copy of the Form and the Agreement. The prospective Representative also signs an individual and Family Directed Supports Agreement. The Individual and Family Directed Supports Agreement is developed by the PIHP and includes the requirements in Appendix R. The Assessments and other required Forms are submitted to the PIHP with the ISP.

- Original forms will be maintained in the participant's file with a copy forwarded to the Employer and Representative.
- An Agency With Choice or Financial Support Agreement is developed/updated to include information about the Representative. These Agreements are developed by the Agencies and are approved by the PIHP.
- If the identified Representative is not approved, the Employer will be asked to identify another Representative. The Employer may file a reconsideration request if they disagree with the decision of the PIHP. The Care Coordinator assists as needed.
- All Agreements must specify the decision making responsibilities of the Representative related to the implementation of the Individual and Family Directed Supports Option. The Employer may designate the Representative as the primary contact for all functions, or limit decision making to specified functions.

The PIHP makes the final determination about the need for a Representative, and approves the person chosen by the Employer to be the Representative. An Employer who has been assessed to need a Representative may not participate in Individual and Family Directed Supports until one is designated. When the opportunity to participate in Individual and Family Directed Supports is questioned because of the need for a Representative or the inability to locate a qualified Representative, the situation will be discussed with the Division of Medical Assistance. If a Representative is required and no one that the Managing Employer identifies is approved to become the Representative, the participant receives services through the Provider Directed Service Option.

There are several instances when it is necessary to change Representative status. These include:

- Adding a Representative when the Employer is serving as the decision maker: This happens when the Managing Employer's situation necessitates it (e.g. the participant has not met his/her responsibilities), or the Employer decides that it is in their best interest. The Procedures for Establishment of an Authorized Representative are followed.
- Removing a Representative and giving decision-making authority to the Employer when the Employer requests to assume this role. The Procedures for Assessment of the Need for a Representative are followed.
- Changing the Representative Decision Maker: A Representative may change for many reasons, including a change in the condition of the Representative, a move by the Representative, the need for the Representative to become the paid caregiver, or a request by the

Employer. The Procedures for Establishment of an Authorized Representative are followed.

Participant Rights, Privileges and Responsibilities

Participants in the Individual and Family Directed Supports Option have rights, privileges, and responsibilities related to accessing information, managing employees, obtaining support, filing grievances and complaints, and withdrawing from the Option.

All applicable laws, rules and regulations must be followed regarding employment, Medicaid, the NC Innovations Waiver, and the Individual and Family Directed Supports Option. This Guide and the PIHP Individual and Family Directed Supports Employer Handbook contain those rules and regulations or reference material for the location for other laws, rules, and regulations that may include but are not limited to:

- Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e, et.seq. (applies to employers with 15+ employees)
- Age Discrimination in Employment Act, 29 U.S.C. §§ 621, et.seq. (applies to employers with 20+ employees)
- The Americans with Disabilities Act, 42 U.S.C. §§ 12101, et.seq. (applies to employers with 15+ employees)
- The Family and Medical Leave Act, 29 U.S.C. §§ 2601, et.seq. (applies to employers with 50 or more employees working 20 or more workweeks per year)
- The Fair Labor Standards Act, 29 U.S.C. §§ 201, et.seq. (applies to all employers)

Employment law is complicated. It is considered a specialty area in the legal profession. The overview in this Guide and the PIHP Employer Handbook should in no way be considered a substitute for competent legal advice.

In the Employer of Record Model, the Employer of Record is responsible for complying with applicable employment laws. In the Agency With Choice Model, the Agency With Choice is responsible for complying with applicable employment laws. The Agency With Choice informs the Managing Employer of employment laws that must be followed.

PIHP Responsibilities

The responsibilities of the PIHP in the Individual and Family Directed Supports Option include:

- Developing an Orientation to Individual and Family Directed Supports and ensuring that Care Coordinators offer to review the Orientation with participants and families at Initial and Annual Plan Development
- Developing an Individual and Family Directed Supports Handbook and distributing or arranging for the distribution of the Handbook to participants/legally responsible persons/representatives who have requested training in Individual/Family Directed Supports
- Contracting with Community Guide Agencies, Financial Support Agencies, and Agencies With Choice, including reviewing policies and procedures of those agencies, as needed
- Developing and/or approving training curriculum(s) for Individual and Family Directed Supports

- Determining the need for a Mandated Representative and approving the proposed Representative, if applicable,
- Determining the need for mandated Community Guide Services,
- Approving the ISP or Update to the ISP that adds the Individual and Family Directed Supports Option and Community Guide Services, as needed by the participant,
- Notifying the Financial Support Agency of the Individual and Family Directed Supports Budget amount, including changes in the Individual and Family Directed Supports Budget amount, if the individual has elected the Employer of Record Model,
- Authorizing Financial Support, Community Guide, and/or Individual and Family Directed Services,
- Approving terminations from Individual and Family Directed Supports with notifications and authorization of Provider Directed Services, including consulting with the Division of Medical Assistance prior to a participant's denial or involuntary termination from Individual and Family Directed Services. If a situation requires involuntary termination from Individual and Family Directed Services on an emergency basis, DMA is notified of the termination on the next business day.
- Providing ongoing support for Individual and Family Directed Supports by maintaining a web site with information about Individual and Family Directed Supports, and
- Arranging periodic meetings for managing employers, which provide opportunities for meetings with key support agencies, including Care Coordinators, Community Guides, Agencies With Choice, and the Financial Support Agency (Agencies).

Minimum Criteria used by the PIHP to approve participation in Individual and Family Directed Supports is located in Appendix R.

Components of Individual and Family Directed Supports

- **Individual and Family Directed Supports Budget**

The PIHP establishes a rate schedule for both models of Individual and Family Directed Supports. The established rates include funds for employee salaries, taxes, cost of benefits, employee training costs, background check costs, and advertising costs. Within the PIHP, the Agency With Choice Model reimbursement rates are the same as those for other NC Innovations Provider Agencies. The Individual and Family Directed Supports Budget (participant directed budget) is the part of the Individual Budget for those services that are participant-directed. The Individual and Family Supports Budget is the total cost of participant-directed waiver services authorized in the ISP. The following principles must be followed in using the Individual and Family Directed Supports Budget:

- Expenditures must be tracked so that the Budget is not overspent. The Financial Support Agency or Agency With Choice performs this tracking on behalf of the Employer. If additional funds are needed they must be authorized by the PIHP. The Employer and Representative, if applicable, are provided with an expenditure report. Employers of Record receive

this report monthly. Agencies With Choice provide Managing Employers a report at least quarterly.

- There are legal requirements for the use of NC Innovations waiver funding. The most basic rules are that everything purchased with NC Innovations funds must be related to the individual's needs and that the funds are used to purchase goods and services that are allowed within the waiver. Funds in the Individual and Family Directed Supports Budget may only be spent for expenditures authorized in the ISP by the PIHP.
- ***Risk Planning, Emergency Plans, and Back-Up Plans***

Planning for employee vacancies and absences is one of the most important things that an Employer and/or Representative will do to prepare to direct services. Each ISP describes how the participant will get their most critical needs met if an employee is absent, a community service becomes unavailable, or some unforeseen circumstance prevents the participant from functioning as usual. Costs must be factored in for using the back-up plan.

For participants who elect the Employer of Record Model, the PIHP maintains a contract with a Provider Agency to provide emergency back-up staffing for individuals in the Employer of Record option. Use of this contract is optional and should be discussed with the Care Coordinator, as the services provided by the Agency will be paid from the Individual and Family Directed Budget. While the contracted Agency will make every effort to provide back-up employees for an individual in case of an emergency, the response will depend on the amount of notice that is given to the Agency.

For participants who elect the Agency With Choice Model, the Agency With Choice is responsible for the back-up staffing needs of individuals. These services are paid out of the billing for the services provided.

It is equally important that plans be made to address potential emergency situations. Potential emergency needs are identified as part of the Risk/Support Needs Assessment process that is used in developing the ISP. The Crisis Plan or ISP states how each identified risk will be managed, and identifies training needs of any individual responsible for implementation of managing a risk management strategy or strategies. Employees are trained to implement the Crisis Plans and/or the plan for managing the risk specified in the ISP that are specifically related to the individual's disability and situation.

Minimum requirements for back-up plans in Individual and Family Directed Supports are:

- The plan provides immediate coverage when the absence of the employee would jeopardize the health and welfare of the participant.
- The plan indicates who to call when back-up staffing is needed.
- The Employer and Representative understand who to call if there are unmet emergency staffing needs, and the back-up staffing plans are not working.

- There is a plan to test/review the back-up plan at least quarterly (Employer of Record Model only). The Agency With Choice's procedures for testing back-up staffing plans are followed.
- The plan identifies risks and ways to manage those risks.
- The plan is specific to the participant.
- The plan uses formal and informal supports.
- There are at least two back-up supports (unpaid supports, paid employees, and/or provider agencies) for each critical service.
- The plan describes a system that is immediately accessible, and that it is realistically operational. A critical service is one that if not provided would result in an immediate risk to the health and safety of the individual.
- The plan identifies emergency responses or plans that will be developed related to weather and environmental emergencies. The Agency With Choice procedures for emergency response plans related to weather and environmental emergencies are followed or the Agency with Choice approves emergency plans developed by the Managing Employer.
- The plan includes the location of contact numbers for emergency situations including 911, PIHP 24 hour Access Line, DSS Adult and Child Protective Services; and the Division of Emergency Management Services.

Care Coordinators and the PIHP monitor Back-Up and Emergency Plans as part of monitoring of services. Any situation that is identified as a health and welfare issue is immediately addressed with the Employer, Representative, and/or Agency With Choice, as applicable. Level One Incident Reports for Back-Up Staffing must be completed by the Employer of Record or Agency With Choice if Back-Up Staffing is not available. A Plan of Correction is required if the failure to provide Back-Up Staffing presents a health and welfare risk to the participant.

- ***Independent Advocacy***

Independent Advocacy is available through advocacy organizations. Participants are notified upon entry of the waiver of the availability of self-referral to an advocacy organization and how to contact the Participant's PIHP. Care Coordinators and Community Guides are also available to assist participants and families in obtaining independent advocacy services.

- ***Employment Protections***

There are a number of protections available to employees and families who elect the Individual and Family Services Option. The PIHP Employer Handbook provides information about these protections. Areas that should be considered by Employers and Representatives include:

- Insurance (Worker's Compensation is required)
- Prevention of Abuse, Neglect and Exploitation
- Medicaid Fraud

Individual and Family Directed Supports Process (Steps)***Information for Participants about Individual and Family Directed Supports***

Step 1: An Orientation to Individual and Family Directed Supports is provided at the time of the Initial and Annual Individual Support Plan (ISP) planning process. Written materials are also given to the participant, family, and/or legally responsible person.

Step 2: When interest is expressed in learning more about directing services, the Care Coordinator:

- Determines who the prospective **Employer** is. The Employer is one of the following individuals:
 - participant;
 - parent(s) of a minor participant; or
 - legal guardian.
 - **A Limited Liability Corporation (LLC) may not be the Employer of Record or Managing Employer.**
- Explains educational opportunities that are available through Community Guide Services. The Care Coordinator may distribute written materials about Individual and Family Directed Supports, including the Employer Handbook or this may be done by the Community Guide during Individual and Family Directed Supports Training.
- Discusses the option of having a Representative, and refers any prospective Representative to the Individual and Family Directed Supports Training provided by the Community Guide. This initial training is required for all prospective Employers and prospective Representatives.
- If the participant does not currently have Community Guide Services, makes a referral for Community Guide Services and adds the Service to the Individual Support Plan.

Step 3: The Community Guide works with the participant, prospective Employer, and/or prospective Representative at a time and location determined by the participant or Employer to:

- Explain educational opportunities that are available through NC Innovations or any other community resources
- Provide a copy of an Individual and Family Directed Supports Employer Handbook and other informational materials to the prospective Employer and/or prospective Representative, as applicable, if not previously distributed by the PIHP
- Provide required initial Individual and Family Directed Supports Training to the participant, Employer, and/or Representative, as applicable. At a minimum the participant or legally responsible person for that individual must be present at the training. The PIHP develops

the standardized training curriculum to be used by all Community Guide Agencies or approves the curriculum developed by the Community Guide Agency. At a minimum the training includes information needed by the prospective employer to make a choice about participating in Individual and Family Directed Supports and the model of Individual and Family Directed Supports the employer wants to utilize (when both models of Individual and Family Directed Supports are available in the PIHP).

Decision Making by the Prospective Employer

Step 4: After the training, the Community Guide issues a training completion certificate to the participant, prospective Employer and/or prospective Representative, as applicable. A copy of the training certificate is sent to the Care Coordinator and a copy of the certificate is retained by the Community Guide.

Step 5: The participant and/or prospective Employer determine if they want to direct services and inform the Care Coordinator of that decision. The participant informs the Care Coordinator of the Model of Individual and Family Directed Supports that the participant has chosen.

Assessment

Step 6: The Care Coordinator completes an Individual and Family Directed Supports Assessment, with the Prospective Employer and Prospective Representative, if applicable. The Individual and Family Directed Supports Assessment is located in Appendix R. The Assessment is customized for the model of Individual and Family Directed Supports chosen by the prospective Employer.

Step 7: If a Representative is desired or required, the Representative Screening Questionnaire is also completed. The Representative Screening Questionnaire and documents associated with the appointment of a Representative are located in Appendix R.

The Assessments are used by the PIHP to:

- Determine if the Prospective Employer has the skills needed to participate in the Individual and Family Directed Supports Option, and if the Managing Employer needs additional Community Guide Services
- Determine if a prospective Representative qualifies to participate in the Option

Step 8: The Care Coordinator provides copies of the Assessments to the Prospective Employer and the Community Guide, if Community Guide Services are continuing beyond the required training.

Individual and Family Directed Supports Agreements

These rights and responsibilities of Employers are outlined in an *Individual and Family Directed Supports Agreement* that the Employer signs prior to the initiation of Individual and Family Directed Supports. The Agreements are in Appendix R. The Agreement is

customized for the two models of Individual and Family Directed Supports. Agreements associated with the Appointment of a Representative are located in Appendix R.

Step 9: The Care Coordinator is responsible for obtaining the completion of the Agreements and answering any questions the Prospective Employer or Prospective Representative may have. The Care Coordinator provides copies of the Agreements to the Prospective Employer, Prospective Representative and Community Guide.

Individual Support Plan (ISP)

Step 10: The Care Coordinator reviews the ISP with the participant, legally responsible person, and representative, as applicable. A decision is made about services that are participant-directed and the services, if any, that will be provided under the Provider Directed Option. In addition to deciding which services are participant-directed, the ISP/ISP Update addresses:

- The model of Individual/Family Directed Supports elected, either Employer of Record or Agency With Choice.
- Employee qualifications and training needs beyond those specified in the General Requirements for all waiver service providers. The parent or step-parent of a child under 18, the participant's spouse, and/or the Employer may not be the employee in the Individual and Family Directed Supports Option. Also these individuals may not provide Qualified Professional Services under the Agency With Choice Model for their family member.
- The plan for back-up staffing in the event that an employee hired is unable to provide services as needed as well as a determination of the emergency and crisis plans or protocols that need to be developed
- A statement of how the participant will be involved in self-directing services if the participant is not the Employer
- Long range outcomes for Community Guide and Financial Support Services, if those services are utilized
- The plan for monitoring services and supports, including how the Care Coordinator, Employer, Representative, and others will jointly ensure the health and welfare of the participant, including the Agency With Choice, if this model has been elected
- The effective date of Individual and Family Directed Supports. This date should be established to allow time for employees to be hired

Step 11: The Care Coordinator prepares the ISP Update and submits it to the PIHP with a minimum of the following information:

- Revised Individual Budget that includes the Individual and Family Directed Budget
- An Individual and Family Directed Supports Assessment
- Representative Assessment, Screening, and Designation of Representative, if applicable

- An Individual and Family Directed Supports Agreement
- Verification of required Individual and Family Directed Supports Option training

Step 12: Upon notification of approval of the ISP, the Employer begins the process of preparing to direct services based on the Model selected, Employer of Record or Agency With Choice.

Addressing Changing Needs

Changes in the participant's situation may require a change in the ISP. The Employer should inform the Care Coordinator of any change in the participant's situation. The Care Coordinator will assist with any needed ISP Updates. The following information describes two kinds of changes that might be needed:

- **Individual Goods and Services:** If the Employer and/or Representative identify a need that can be met under Individual Goods and Services, they identify the potential cost and source of obtaining the needed good or service. The Community Guide assists as needed. The Employer and/or Representative discuss the need with the Care Coordinator. The Employer, Representative and Care Coordinator review the Individual Budget to determine the availability of funds. Individual Goods and Services are an "Add On" to the Individual Budget; however the Annual Waiver Cost Limit may not be exceeded. When funds are available, the Care Coordinator prepares the ISP Update. For Updates that are approved, an authorization is sent to the Agency With Choice who purchases the good or service on behalf of the participant. The expenditure is entered into the Financial Support Agency or Agency With Choice Report Inventory. The Care Coordinator verifies that the approved good or service was obtained. See Chapter 13 of this Guide for additional information about Individual Goods and Services.
- **Other Needed Service Changes:** Requests for changes in other parts of the ISP, including changes in frequency and/or duration of services are described in Chapter 10 of this Guide. Changes in duration or frequency of services must be requested by contacting the Care Coordinator who will prepare a Plan Update.

Employer of Record Model Financial Support Services

Financial Support Services are utilized by Employers of Record for paying employees, and ensuring that other fiscal functions are completed. Financial Support Services is a required service for participants who choose the Employer of Record Model of Individual and Family Directed Supports. Even though the Financial Support Agency manages all payroll functions, the adult waiver participant, parent(s) of a minor waiver individual, or legal guardian is considered the Employer of Record (common law employer). Financial Support Services assure that Individual and Family Directed funds outlined in the ISP are managed and distributed as intended. The cost of Financial Support Services is paid out of the Individual Budget as an add-on to that Budget. Financial Support Services are authorized by the PIHP. See Chapter 13 of this Guide for additional information about Financial Support Services.

Step 1: The Financial Support Agency provides the Employer and Representative, if applicable, with written materials about the Agency's

services. This includes the toll free number and business hours of the Agency. Whenever Financial Support Agency procedures change, the Employer and Representative will be notified of those changes in writing.

Step 2: Once Financial Support Services are authorized for a participant, the Financial Support Agency submits a written application and authorization to the Director of the Internal Revenue Service Center. This application notifies the IRS that the Financial Support Agency is authorized to act on behalf of the Employer of Record (the person designated in the referral form) in fiscal and tax matters. Once this application is approved by the IRS Service Center Director, a letter of authorization is sent to the agent. Authorization is effective the date the letter is postmarked. The Financial Support Agency also files for a federal tax identification number on behalf of the Employer of Record.

Step 3: A Financial Support Agreement is completed which outlines the functions that the Financial Support Agency will perform and the functions that the Employer of Record and representative, if applicable perform. The content of the Financial Support Agreement is approved by the PIHP. The Financial Support Agency provides the Agreement to the Employer of Record, and maintains the original Agreement and Amendments to the Agreement. A copy of the completed, signed Agreement is forwarded to the Employer of Record and Representative, if applicable.

Step 4: Once an employee is selected by the Employer of Record and/or Representative and approved by the PIHP, the Financial Support Agency provides the Employer of Record or representative an **Employee Hire Packet** that includes the forms needed to get the employee signed up to begin work. This packet also includes instructions about time sheets and payroll schedules as well as where to send information and when. The Financial Support Agency provides Employers of Record with written materials that include a list of forms that are included in the Employee Hire Packet.

Step 5: The employee keeps time sheets that must be verified and are approved by the Employer of Record and/or representative. These time sheets are submitted to the Financial Support Agency on an agreed upon schedule. The Financial Support Agency generates a paycheck for the employee and distributes it to the employee. The Financial Support Agency completes withholding, inclusive of taxes and benefits. These include taxes required by law and additional benefits agreed upon by the Employer of Record and/or representative. The Financial Support Agency bills the PIHP for all services provided during that month. The Financial Support Agency also withholds taxes as required by law from the employee's pay. The Financial Support Agency provides written information to the Employer of Record or representative, if applicable, about tax withholdings, and answers questions about withholdings.

The Financial Support Agency is required to bill the PIHP for services within a specified time. It is important for the Employer of Record to understand and submit time sheets and service billing information to the

Financial Support Agency in a timely manner. Late claims could result in non-payment of service billing, decreasing the funds available in the Individual and Family Directed Budget.

The Financial Support Agency keeps the following types of records:

- A record for each participant that uses Financial Support Services, including both labor and non-labor expenses
- A record for each employee hired
- Records for all billings and reports to the PIHP
- Copies of monthly expenditure reports

Each month, the Employer of Record and representative, if applicable, receives a report of the previous month's expenditures and revenues (billing of Medicaid services). This information is also sent to the Care Coordinator. The Employer of Record and/or Representative are responsible for making sure that records are accurate and complete. If there are questions about the reports, the Financial Support Agency should be contacted right away. The Community Guide is also available to help in understanding the report.

The Financial Support Agency notifies the PIHP when:

- Spending is more than 15% of the projected prorated budget year to date
- Spending is less than 50% of the projected prorated budget year to date
- Spending of funds budgeted for staffing is more than 15% of the projected prorated budget year to date
- Spending of funds budgeted for staffing is less than 50% of the projected prorated budget year to date
- Notices that have been issued to Employers of Record and/or Representatives requesting missing required information such as invoices, timesheets, or there have been requests to purchase services not included in a treatment authorization. The PIHP is notified immediately if the Employer of Record requests payment for expenses that exceed the Individual and Family Directed Budget.

Medicaid Funds are not used to purchase fax machines, computers, or telephone lines for Employers in Individual/Family Directed Supports. While Employers may voluntarily choose to use their own personal equipment for communicating with the Financial Support Agency, the Financial Support Agency provides self-addressed stamped envelopes for Employers to use in sending required forms and other documents to the Financial Support Agency.

Employer of Record Model Hiring Processes

The PIHP Individual and Family Directed Supports Employer Handbook contains information about hiring employees. In the Employer of Record Model, the PIHP specifies the degree that the Employer of Record may modify any forms in the Handbook. Once a prospective employee is identified, the Employer of Record and/or Representative provide information to the Financial Support Agency that is needed to conduct required background checks. Information needed is located in the written materials provided by the Financial Support Agency. There is no charge to the individual,

Employee of Record and/or Representative for the background checks. The charge for the performance of background checks is paid from the Individual Budget. The required background checks are:

- Age verification (Employer obtains from prospective employee)
- If the employee will transport the participant, driving record check
- Criminal record background check as required by North Carolina law
- Health Registry check

The Financial Support Agency obtains the background check and arranges for the results to be sent to the Employer and/or Representative. They review the background checks and determine if they wish to hire the applicant. Prior to offering a position to an applicant, the Employer and/or Representative make sure that the applicant is qualified for the position. All employees of Employers of Record must submit a copy of the employee's social security card to the Financial Support Agency prior to the employee's work start date.

If the Employer of Record decides to hire an applicant, the Employer and/or Representative offer the position to the applicant. If the applicant accepts employment, the Employer of Record, and/or Representative make sure that the Hire Packet is completed, including any forms that the employee must sign. They also develop an Employee Support Agreement that is signed by the Employer and Representative, if applicable, and employee. The Employer of Record develops the Employee Support Agreement and includes minimum requirements established by the PIHP that are included in the Employer Handbook. The Employer of Record cannot hire an employee prior to receiving the background check.

The Employer and/or Representative return the Hire Packet to the Financial Support Agency. Original forms are sent to the Financial Support Agency. The Financial Support Agency completes all required federal, state and PIHP forms for individual of services.

Establishing Employee Pay Rates

The Care Coordinator informs the Employer of the amount of the Individual and Family Directed Budget. In the Employer of Record Model, the Employer of Record determines the employee pay rate. The amount of the Individual and Family Directed Budget must be considered, as well as employer taxes, and other expenditures that must be paid from the Individual and Family Directed Budget. The PIHP provides the Employer of Record with a computer based auto calculator. The Community Guide assists with the use of the auto-calculator and access to a computer, as needed.

Training Employees

In the Employer of Record Model, it is the responsibility of the Employer of Record and/or Representative, if applicable, to train direct service employees. At a minimum, employees must meet requirements specified in this Guide, in the ISP, and in any applicable NC State Rule. The PIHP Individual and Family Directed Supports Employer Handbook has additional information about training employees. The Employer maintains copies of documents and certificates in the employee's personnel file. Training needs are identified and a plan to train the employee is developed. The Employer or Representative may provide needed training, or may arrange for the training to be provided by another person or agency. Employers of Record must plan for the cost of

training and any reimbursement to employees participating in training while not providing services to the participant. Payment for training and employment reimbursement must be considered in budgeting funds in the Individual and Family Directed Budget.

Employer Record Keeping

In the Employer of Record Model, it is important that the Employer of Record or Representative keeps a file on each employee that is hired. Copies of important documents, such as the application and Employee Support Agreement, are maintained in the file. Information about employees is confidential and is kept in a secure location. Records are subject to review by the Care Coordinator, PIHP, and/or the state or federal governments.

The Employer of Record maintains the results of the criminal record check. Specific information about an applicant's criminal record check is not sent to the PIHP or the Financial Support Agency, or disclosed to anyone conducting a monitoring or an audit. The Employer of Record may not hire an applicant whose criminal record or Health Care Registry check pose a potential health and welfare risk to the participant.

Service Documentation

It is critical that all services billed to Medicaid be properly documented as required in this Guide. The documentation must be sufficient so that it is understandable, explains the service that was provided, and can be verified with reasonable certainty that the service was actually provided. Documentation must be kept a minimum of 11 years after the last date of contact for an adult and 12 years after a minor reaches the age of majority (18 years of age).

With the Employer of Record Model, the Employer of Record and/or Representative are responsible for developing short range goals and task analysis/strategies for achieving long range ISP outcomes. Employees complete necessary clinical documentation and submit this to the Employer and/or Representative. The documentation is maintained in a secure location.

Agency With Choice Model**Agencies With Choice**

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 Directed Supports Option and that are designated by the PIHP as Agencies With Choice. The PIHP requires specific assurances in each Agency With Choice's contract that require the Agency with Choice to maintain policies and procedures that support the control and oversight by participants and/or Managing Employers over employees. These policies and procedures are subject to approval by the PIHP. Agencies with Choice attend PIHP sponsored trainings and participant/family meetings in Individual and Family Directed Supports.

Agencies With Choice perform the financial support functions for Managing Employers in the Agency With Choice Model. The cost of these activities is built into the service rate for the direct services billed by the Agency With Choice. The Agency With Choice serves as the common law employer with federal and state agencies for employees hired to provide services to participants.

Step 1: The Agency With Choice provides the Managing Employer and representative, if applicable, with written materials about the Agency's services. This includes the toll free number and business hours of the Agency. Whenever Agency With Choice procedures change, the Managing Employer and representative, if applicable, will be notified of those changes in writing.

Step 2: An Agency With Choice Agreement is completed that outlines the functions that the Agency With Choice performs and the functions that the Managing Employer, or Representative performs. The PIHP establishes minimum requirements for the Agreement. The Agency With Choice provides the Agreement to the Managing Employer, and maintains the original Agreement and Amendments to the Agreement. A copy of the completed, signed Agreement will be forwarded to the Managing Employer and Representative, Care Coordinator if applicable.

Additional Steps: The Agency With Choice performs these additional tasks per the Agency With Choice's policies and procedures:

- Hiring and/or firing employees based on recommendations of the Managing Employer (participant/legally responsible person)
- Maintaining personnel records on employees
- Filing claims for Individual Family Directed Supports and services
- Payment of payroll to employees hired to provide services and supports
- Deducting all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paycheck
- Administration of benefits for employees hired to provide services and supports
- Requesting and reviewing criminal background checks, driver's license checks, and health care registry checks of prospective employees providing participant directed services
- Carrying Workers Compensation Insurance coverage on employees
- Ordering employment related supplies
- Providing or arranging for training of employees
- Purchasing authorized Individual Goods and Services on behalf of the participant
- Providing Qualified Professional supervision of services, including oversight and maintaining clinical documentation of services provided
- Providing documentation for audits as requested by local, state, federal agencies

The Agency With Choice keeps the following types of records:

- A record for each participant
- A record for each employee hired
- Records of all claims and reports to the PIHP
- Copies of quarterly expenditure reports that are provided to the Participant and the Participant's Care Coordinator (minimum or services authorized versus services billed)

At least quarterly, the Managing Employer and representative, if applicable, will receive a report from the Agency With Choice of the previous month's revenues (Medicaid services units billed, including Individual Goods and Services) with the units of services authorized during that month. If there are questions about the reports, the Agency With Choice should be contacted. The Community Guide is also available to help in understanding the report. The Agency With Choice notifies the PIHP if the Managing Employer has scheduled employees to provide services that are not authorized by the PIHP.

Agency With Choice Hiring Processes

In the Agency With Choice Model, the Managing Employer recommends applicants for hire to the Agency With Choice. The Agency With Choice requests background checks as required by the Waiver, State Rule, and Agency Policy. The Agency With Choice reviews the results of the background checks and informs the Managing Employer if the applicant may be hired.

The Agency With Choice offers the position to the applicant. If the applicant accepts employment, the Managing Employer and/or Representative works with the Agency With Choice to make sure that forms needed to hire the applicant are completed and signed. They also develop an Employee Support Agreement that is signed by the Managing Employer and representative, if applicable, Agency With Choice, and employee. The Agency With Choice completes all required federal, state and PIHP forms for hiring employees.

Agency With Choice Establishment Employee Pay Rates

The Care Coordinator informs the Employer of the amount of the Individual and Family Directed Budget. In the Agency with Choice Model, the Agency With Choice uses the Individual and Family Directed Budget to pay employees, employer taxes, and other expenditures. The Agency With Choice determines the employee pay rate and employee benefits, involving the Managing Employer as indicated in their Agency With Choice's policies and procedures. The Agency With Choice includes information about the way the Agency establishes employee pay rates in materials provided to Managing Employers.

Training Employees

With the Agency with Choice Model, the Managing Employer and/or Representative, if applicable, works cooperatively with the Agency With Choice to train direct service employees. The Agency With Choice is responsible for making sure that employees meet requirements specified in this Guide, in the Individual Support Plan and in any applicable NC State Rule. The Agency With Choice maintains copies of documents and certificates in the employee's personnel file. The cost of training is paid by the Agency With Choice out of the direct service reimbursement rate paid for the Individual and Family Directed services provided.

Employer Record Keeping

The Agency With Choice keeps the Personnel File on each employee in this Model. Copies of important documents, such as the application and Employee Support Agreement, are maintained in the file. Information about employees is confidential and is kept in a secure location. Records are subject to review by the Care Coordinator, PIHP, and/or the state or federal governments.

The Agency With Choice maintains the results of the criminal record check. Specific information about an applicant's criminal record check is not sent to the PIHP or disclosed to anyone conducting a monitoring or an audit. The Agency With Choice does not disclose the results of the criminal record check to the Managing Employer or Representative. The Agency With Choice may not hire an applicant whose criminal record or Health Care Registry check pose a potential health and welfare risk to the participant.

Service Documentation

It is critical that all services billed to Medicaid be properly documented as required in this Guide. The documentation must be sufficient so that it is understandable, explains the service that was provided, and can be verified with reasonable certainty that the service was actually provided. Documentation must be kept a minimum of 11 years after the last date of contact for an adult and 12 years after a minor reaches the age of majority (18 years of age).

With the Agency With Choice Model, the Agency With Choice is responsible for developing short term goals and task analysis/strategies for achieving long range ISP outcomes while working with the Managing Employer and/or Representative to assure that the participant's needs are met. Employees complete necessary clinical documentation and submit this to the Agency With Choice. The documentation is maintained by the Agency With Choice. A Qualified Professional in the field of developmental disabilities oversees the provision of services and the documentation of those services. The Managing Employer may not provide Qualified Professional Services under the Agency With Choice Model for their family member.

Quality Assurance and NC Innovations Individual and Family Directed Supports

Employers, Representatives, Financial Support Services Agencies, Community Guide Agencies, and/or Agencies With Choice are responsible for helping the PIHP make sure that the participant receives quality services. The Care Coordinator, PIHP, and the State of North Carolina have key roles in the quality of Individual and Family Directed Supports Option.

Employers, Representatives and/or Agencies With Choice cooperate in contacts and visits by the Care Coordinator. They inform the Care Coordinator if they believe the needs of the participant are not being met, and safety and well-being are compromised. The Care Coordinator follows-up, including making a home visit to evaluate and assist. Follow-up will be immediate if the situation appears to be an emergency. Employers, Representatives and/or Agencies With Choice must report suspected abuse or neglect of the participant to the Department of Social Services, Healthcare Registry and the PIHP. Incident Reports must be completed and submitted to the PIHP as required by State Rule and the NC Innovations Waiver. The Employer and Representative decide if they are satisfied with services provided under the Individual and Family Services Option.

The Care Coordinator's monitoring of services includes a monthly face-to-face contact with the participant. The Care Coordinator reviews service documentation and contacts the Employer, or Representative, if applicable, monthly. The Care Coordinator reviews monthly expenditure reports prepared by the Financial Support Agency and Quarterly Reports prepared by the Agency With Choice against the Individual and Family Directed

Supports Budget. If there are significant deviations in actual versus planned spending, the Care Coordinator contacts the Employer, Representative, and/or Agency with Choice to determine if a problem exists.

In monitoring the implementation of Individual and Family Directed Supports, the Care Coordinator, through contacts and observation of service delivery, considers the following areas:

- How often employees fail to report to work
- Use of back-up employees
- Changes in employees
- Participant and family satisfaction with quality of services
- Participant and family satisfaction with quantity of services
- Flexibility in the participant's schedule
- Level of participation in community involvement
- Sufficiency of the Individual Budget
- Satisfaction with overall Individual and Family Directed Services process, particularly with Training, Community Guide Services, Financial Support Services and the Agency With Choice
- Other complaints/concerns/suggestions.

The PIHP monitors all aspects of the Individual and Family Directed Supports Option. Monitoring includes:

- Monitoring the Financial Support Services provider(s) annually
- Monitoring the Community Guide Services provider(s) and Agencies With Choice at a minimum of at least once every three years
- Reviewing incident reports
- Providing training and technical assistance in completion of incident reports and service documentation for participants who elect the Employer of Record Option
- Reviewing a sample of back-up staffing plans at least annually to ensure that they function properly
- Reviewing complaint logs maintained by the PIHP, Financial Support Agencies, Agencies With Choice and Community Guide Agencies at least semi-annually

The PIHP conducts an annual monitoring of participants in Individual and Family Directed Supports. The Employer of Record and Representative, if applicable, are notified of the scheduled review. Annual Reviews may include:

- Interviews with the participant and their family
- Record reviews (both consumer and employee records)
- Employee and/or Employer interviews
- Incident report reviews
- Reviews of training and supervision documentation
- Reviews of service documentation

The Employer and Representative, if applicable, are provided a copy of the Annual Review Report. Findings may be disputed via a dispute resolution proceeding.

The State of North Carolina (DMA and the Intradepartmental Monitoring Team) also has extensive responsibilities in assuring quality: The State:

- Completes retrospective reviews of samples of ISPs and Individual and Family Budgets
- Reviews a sample of Community Guide and Agency With Choice Monitoring Reports
- Review the PIHP reviews of Financial Support providers

Additional Technical Assistance and Support

An Employer's need for additional technical assistance and support could be identified by the Community Guide, Agency With Choice, Financial Support Agency or other individuals, or be identified as a result of problems discovered during monitoring by the Care Coordinator, PIHP, or State. The participant may be the subject of a suspected abuse report, or assistance could be needed to resolve problems encountered in plan implementation or services management. While not an inclusive list, the matters that might indicate a need for additional technical assistance and support include:

- Not utilizing enough for services needed to support health and welfare without reasonable explanation
- Not receiving services, equipment or goods identified as critical for health and welfare
- Utilizing the Individual and Family Directed Supports Budget at a rate that suggests that the ISP will not be sustainable over the plan year
- On-going difficulty in arranging for services needed for health and welfare
- Unapproved expenditures
- Inability to supervise or fire an employee effectively
- Failure to respond to notices requesting missing information from the Financial Support Agency or Agency With Choice
- Not implementing the ISP as approved

Each discovery of non-compliance is documented and sent to the PIHP, with the Care Coordinator, assisting as needed. The PIHP determines the next action step which could include but is not limited to:

- Referral to the Department of Social Services Protective Services Department
- Requiring that a formal plan of correction be submitted and implemented
- Requiring technical assistance (the need for PIHP staff involvement above and beyond the standard training and materials)
- Requiring that a representative be appointed to assist the Employer
- Requiring that Community Guide or additional Community Guide services be added to the ISP
- Recommending that the participant be terminated from the Individual and Family Directed Supports Option

Termination from Individual and Family Directed Supports

An Employer of Record or Managing Employer may withdraw from Individual and Family Directed Supports at any time by notifying the Care Coordinator. The Care Coordinator will prepare a revision to the ISP, and submit the revision to the PIHP so that Provider Directed Services are authorized for the person.

An Employer of Record or Managing Employer may be removed from Individual and Family Directed Services involuntarily under the following circumstances:

- Immediate health and concern, including maltreatment of the participant
- Repeated unapproved expenditures/misuse of NC Innovations funds
- Suspected fraud or abuse of funds or evidence of unreported fraud
- No approved representative available when the Employer is determined to need one
- Refusal to accept the necessary Community Guide Services
- Refusal to allow Care Coordinator to monitor services
- Refusal to participate in PIHP, state, or federal monitoring
- Non-compliance with Individual and Family Directed Supports, Financial Support Agency, Agency with Choice and/or Employee Support Agreements
- Inability to implement the approved ISP or comply with NC Innovations requirements despite reasonable efforts to provide additional technical assistance and support (fourth event requiring additional technical assistance/corrective action plan in 12 months).

Normally Employers are terminated from the Individual and Family Directed Supports Option if the same major mistake occurs more than three times in a one-year period. However, the recommendation can occur at any point when the participant's health and welfare are at risk or if Medicaid fraud 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 assure health and welfare.

Concerns and/or allegations of major problems with the implementation of Individual and Family Directed Supports are reported to the PIHP or are sometimes discovered by the PIHP during the Plan approval or Utilization Review processes. The PIHP investigates the concerns or allegations of major problems. Depending on results of the investigation, the PIHP considers one of these options:

- Continuation in Individual/Family Directed Supports
- Continuation in Individual/Family Directed Supports with considerations such as changing models, mandated Community Guide Services, additional training and/or mandated Representation
- Termination of Individual and Family Directed Supports

The PIHP discusses the recommendation with the Division of Medical Assistance to gain their input on the decision to remove the participant from the option. If there is agreement between PIHP and DMA, the Employer is notified of their termination from the option and offered their grievance rights. 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 participant's health and welfare, such as physical abuse, termination should occur immediately, and Provider Directed Services should resume immediately. DMA is notified of any emergency terminations.

It is important to remember that termination from the Individual and Family Directed Supports Option does not mean that the participant is terminated from the NC Innovations Waiver. Participants who are terminated from Individual and Family Directed Supports, either voluntarily or involuntarily, return to the Provider Directed

Supports Option of the NC Innovations Waiver. The Care Coordinator and the PIHP work together to prepare and approve an ISP Revision that allows the participant to move to Provider Directed Services without service interruption. Participants terminated from the Individual and Family Directed Supports Option may not return to the Individual and Family Directed Supports Option for at least 90 days from the date of their return to Provider Directed Supports. They also must repeat all initial trainings and assessments.

Medicaid Eligibility

This section gives general information about Medicaid as well as information specific to NC Innovations. Guidance for Department of Social Services (DSS) staff is in the [Aged, Blind & Disabled Medicaid Manual](#) and [EIS \(Eligibility Information Systems\) Manual](#). The details of Medicaid eligibility require considerable expertise to interpret and are the responsibility of the Department of Social Services.

Medicaid Basics

Medicaid pays for medically necessary services for certain people with limited income. Title XIX of the Social Security Act contains the federal law for Medicaid. CMS carries out the law by writing regulations and overseeing each state's operation of the program. States have some flexibility within the Federal law and regulations to have their own rules. Federal and state funds pay program costs.

Many aspects of Medicaid are similar to private health insurance. There are ID cards and computerized records to show eligibility, deductibles to be met in certain situations, co-payments for some services, and prior approval requirements for certain coverage. Just as a private insurer's coverage may not be the same for all policyholders, Medicaid coverage differs across categories of recipients.

The following gives basic information about Medicaid. This chapter provides information on how the policies and procedures differ for an NC Innovations recipient.

Who's Involved?

The Division of Medical Assistance (DMA), in the Department of Health and Human Services (DHHS), administers Medicaid in North Carolina. DMA establishes the rules and procedures for the program and directs its operation. DMA activities must follow Federal guidelines.

Care Coordinators should assist in assuring that care is appropriate, medically necessary and provided according to Medicaid guidelines. The efforts of Care Coordinators are needed to get the best care for waiver recipients as well as the best use of the public funds. Medicaid recipients and those who assist them are also important to the success of the program. Care Coordinators should not try to be Medicaid experts, and should not advise participants, their families, or their caregivers about Medicaid eligibility. They should always refer them to the county DSS Medicaid Staff. While this Chapter and Guide refer to the Care Coordinator's responsibilities in the coordination of Medicaid eligibility, the PIHP may have policies and procedures that define the role of other departments/staff in assisting with these processes.

County Departments of Social Services (DSS) accepts Medicaid applications and determines Medicaid eligibility. DSS uses state-issued policies to determine eligibility.

Provider agencies, physicians and other health care professionals provide care and confirm that care orders are appropriate to the recipient's needs. These individuals help assure the quality and the cost-effectiveness of care.

Who's Eligible for Medicaid?

Medicaid eligibility is a separate issue from eligibility for NC Innovations and eligibility for a specific service. People who receive Supplemental Security Income (SSI)

automatically receive Medicaid in North Carolina. Other individuals may receive Medicaid if they are in an eligible group or category and meet North Carolina Medicaid income and assets limits. These individuals must apply for Medicaid and be determined eligible by DSS in the county in which they live. Eligibility may be based on a variety of factors, including being aged, blind or disabled; receiving assistance from such programs as Special Assistance, Temporary Assistance to Needy Families (TANF), Supplemental Aid to the Blind, and other specific assistance programs; being pregnant; and being under 21 years of age. Medicaid Eligibility is linked to the income and, usually, the resources of the individual. It may also involve the income and resources of parents and spouses.

Applying for Medicaid

Not everyone on Medicaid may participate in NC Innovations. It is important that the PIHP contact DSS when considering a new individual for waiver services. When an individual applies for SSI, the application is also an application for Medicaid. Individuals apply for SSI at their local Social Security Administration office.

Individuals, who are not eligible for SSI, apply for Medicaid at the DSS in the county in which they reside. The county DSS has 45, 60 or 90 days to act on the application, depending upon the type of application and whether disability needs to be established. The Medicaid staff will ask for the income and resources of the participant and parent/spouse when the potential NC Innovations participant applies for Medicaid. The DSS is required to look at all ways that a person may be eligible for Medicaid. In some instances, this will be advantageous for the individual, as it will allow the individual to have regular Medicaid before the NC Innovations Individual Support Plan is approved and services are authorized. The PIHP should inform parents and spouses that DSS may ask them about income and resources at the time of application.

When applying for Medicaid, the individual should bring:

- Birth certificate or other proof of age.
- Social Security card.
- Proof of income, such as paychecks, wage stubs, and copies of Social Security and Veteran's (VA) checks or a letter verifying the benefit amounts.
- Life insurance and medical insurance policies.
- Savings account books and bank statements
- Information on ownership of real property and motor vehicles.
- Medical bills.
- In addition, if the SSI or Medicaid eligibility is to be based on disability and the applicant is not receiving Social Security disability benefits, the applicant will have to provide medical information and have an examination by a physician. The examination will be paid for by the State. The agency that determines disability is the Disability Determination Section of the NC Division of Social Services.

Retroactive Eligibility for Regular Medicaid Services

Medicaid eligibility usually begins the month of application. A person may apply for coverage for one, two or three months prior to the month that the Medicaid becomes effective. Medicaid payment is available for regular Medicaid services provided during this period on a retroactive basis if all requirements for the service are met. The dates

on the Medicaid ID card will show this type of eligibility. If a NC Innovations Waiver participant is determined to be eligible for participation in the NC Innovations Waiver retroactively, DMA will work with the PIHP to ensure payment for these services.

Deductibles

A Medicaid deductible (also referred to as a "spenddown") is similar to a private insurance deductible. Medicaid will not pay for services while an individual is in deductible status. It is the amount of medical expenses for which the recipient is responsible before Medicaid will pay for covered services. Unlike private insurance, the Medicaid deductible is based on income; therefore, the amount is not the same for each person. DSS must be consulted to obtain information about how the deductible is determined. For NC Innovations Waiver participants, the deductible is calculated over a six-month time period, and is divided into six monthly payment amounts. On the date that medical expenses for the month total the designated amount, the recipient will be approved for Medicaid coverage for that date through the end of the monthly eligibility period.

SSI recipients do not have a deductible. Other individuals who meet all eligibility requirements except the income limit may have a deductible. If an individual is determined by DSS to have a deductible, these individuals are responsible for their health care costs until they incur medical bills equal to the amount of income over the limit. Once the individual has met the deductible amount, Medicaid pays for covered services during the eligibility period.

The important points to remember about deductibles are:

- Medical expenses that can usually be used to meet a deductible include but are not limited to the following:
 - a. Hospital charges;
 - b. Clinic and laboratory charges;
 - c. Charges by dentists, physicians, therapists, and NC Innovations Service Provider Agencies;
 - d. Prescription drug charges;
 - e. Charges for "over-the-counter" medicines and medical supplies;
 - f. Medically related transportation costs;
 - g. Charges for dentures, eyeglasses, hearing aids, walkers and other medical equipment;
 - h. Dietary supplements such as "Ensure" if prescribed by a physician;
 - i. Premiums paid by the individual for private health insurance; and
 - j. In addition to the usual expenses allowed toward a deductible, a participant receiving NC Innovations funding may use the cost of NC Innovations services approved on the Individual Support Plan if they are provided during the deductible period.
- The expense must be incurred by the individual to apply to the deductible - bills in advance of the delivery of a service may not be applied.
- The individual must be responsible for all expenses that count towards the deductible (the Individual must pay for the deductible out of his or her resources). There is one exception involving expenses paid with local or State government funds - DSS will apply this exception when appropriate.

- If an expense is partly paid by private insurance, Medicare, or another third party, only the portion that is the individual's responsibility counts towards the deductible.
- If the individual is billed based on a sliding fee schedule, only the amount for which the individual is responsible applies to the deductible.
- A person on a deductible uses bills and receipts to meet the deductible, therefore, it is important that these items are obtained and given to DSS as quickly as possible.
- While a person is meeting a deductible, the individual is not covered by Medicaid and will not have a Medicaid ID card. Medicaid will not pay for services while the person is in a deductible status.
- Usually, only current expenses apply to a deductible; however, there is a provision which allows an individual to apply an unpaid balance of a medical expense incurred in the 24 months prior to the current certification period. DSS will explain this provision to the individual.
- The waiver participant or his/her legal representative is responsible for payment of bills that apply towards the participant's deductible. A Provider Agency may refuse to serve a participant who does not pay the bill submitted to the participant/legally responsible person to apply towards their deductible; however, the participant will not be removed from NC Innovations for failure to pay deductible bills.

Care Coordinators are responsible for coordinating deductibles with the DSS Medicaid Worker, Provider Agencies, and the person/legally responsible person. Care Coordinators assisting participants with a deductible should work with the DSS Medicaid worker to learn what expenses may apply and the best method to get the information quickly to the worker. Some Care Coordinators collect the bills and receipts to help expedite getting the information to DSS and the person authorized for Medicaid.

Co-Payments Medicare Part D

Some Medicaid coverage requires a co-payment by the Medicaid recipient. Visits to physicians, chiropractors, dentists and optometrists, as well as prescriptions, are examples of services that may require a co-payment. NC Innovations recipients are exempt from these co-payments. Provider Agencies are periodically reminded of the exemption in the Medicaid Bulletin and for pharmacists, the Medicaid Pharmacy Newsletter. If a Provider Agency is not aware of the exemption, it should be suggested that the Provider Agency contact DMA. The "IN" indicator in the waiver block on the Medicaid ID card alerts the Provider Agency to the exemption. Co-payments may be different for participants who have Medicare **and** Medicaid.

Prior Approval

Some Medicaid services require prior approval before Medicaid will cover the service. Examples include nursing facility care, ICF-MR care, 1915(c) Home and Community Based Waivers such as NC Innovations, some durable medical equipment, certain dental coverage and private duty nursing.

Medicaid Eligibility and Innovations

The following gives basic information on how Medicaid policies and procedures differ for an NC Innovations recipient.

Waiver of the Deeming of Income and Resources

When a member of a married couple, living together, applies for Medicaid, the spouse's income and resources count towards the applicant's eligibility. When a child living with his parent(s) applies for Medicaid, the income and usually the resources of the parent(s) are considered in determining the eligibility of the child. This is called the "deeming" of income and resources. When the spouse or child is in institutional care under specific conditions, deeming may not apply. Because NC Innovations is an alternative to ICF-MR care, CMS has allowed North Carolina to waive the deeming requirement. The income and resources of a parent or spouse are not considered in determining the person's Medicaid eligibility.

Which Medicaid Categories Are Eligible for North Carolina Innovations

Though there are a variety of categories in Medicaid, only Medicaid recipients in the following coverage groups may receive NC Innovations:

- Medically needy in 1634 State and SSI individuals
- Optional State supplement individuals
- Optional categorically needy aged and/or disabled individuals who have income at 100% of the federal poverty level:
 - a. Medicaid to the Aged (M-AA)
 - b. Medicaid to the Blind (M-AB)
 - c. Medicaid to the Disabled (M-AD)
 - d. State/County Special Assistance to the Aged (S-AA)
 - e. State/County Special Assistance to the Disabled (S-AD)
- 42 CFR 435.135 (pass along)
 - a. Individuals under 42. CFR 435.115(e) (1) Title IV-E adoptive children
 - b. Individuals under 42. CFR 435.115(e)(2) Title IV-E foster children

Medicaid categories/Persons not eligible for North Carolina Innovations

The following categories of people receiving Medicaid are not eligible to enroll with the PIHP and cannot participate in the NC Innovations Waiver:

- Medicare Qualified Beneficiaries (MQB)
- Non-qualified Aliens or Qualified Aliens during the five (5) year ban
- Medically Needy in deductible status
- Individuals with Presumptive Eligibility
- Refugee Assistance (MRF and RRF)
- Family Planning Waiver Individuals (MAF_D)
- North Carolina Health Choice Individuals

Effective Date of NC Innovations

The effective date that coverage of NC Innovations services begins is the latest of:

- The Medicaid application date;
- The NC Innovations Level of Care approval date
- The date of deinstitutionalization

An individual new to NC Innovations may not enter the NC Innovations waiver prior to the participant's movement into a private home or facility with six or fewer licensed beds

that qualifies under the NC Innovations waiver. Facilities must also meet the home and community characteristics as defined in the waiver. Chapter 1 and 13 provide further explanation about facilities that NC Innovations participants may live in, including an explanation of facility requirements to meet home and community characteristics.

Retroactive coverage is not available for NC Innovations services.

Verifying Medicaid Eligibility

Care Coordinators must be sure that the participant receiving NC Innovations funding is authorized for Medicaid and eligible for NC Innovations services. A new Medicaid card is issued each year. The PIHP verifies Medicaid eligibility and eligibility for NC Innovations by checking the person's eligibility in the Medicaid Management Information System. This includes monthly verification of the following in the Medicaid Management Information System:

- County Code: The county code must be a county in the PIHP area.
- Waiver Indicator: This indicates that the participant is covered under NC Innovations.
- Medicaid Program Type
- Participant's Identify: The person's name is in the system as Eligible for Medicaid.
- The participant's Medicaid ID number (MID) is listed.

The indicator for the NC Innovations waiver is "IN". It is important that both the county code and the indicator are correct for a Medicaid participant to be correctly assigned to the NC Innovations waiver. Other Waiver indicators include:

- CAP-MR/DD: CM
- CAP-MR/DD Supports Waiver: C2
- CAP-C, Hospital Care: HC
- CAP-C, Skilled Care: SC
- CAP-DA, Intermediate Level: CI
- CAP-DA, Skilled Level: CS
- CAP-DA/CAP-Choice Option, Intermediate Level: ID
- CAP-DA/CAP-Choice Option, SD

If any of the NC Innovation areas are incorrect or missing, the Care Coordinator contacts DSS to correct the information. Payment is not made for NC Innovations services unless the eligibility system shows the person's Medicaid is from the PIHP area, the person's waiver indicator is for the NC Innovations waiver, and the Medicaid Program Type is one of the categories that allow NC Innovations coverage.

Medicare

For participants who also have Medicare, this must be noted. If both Medicare and Medicaid allow the same service, Medicaid will pay the lesser of:

- The Medicare cost sharing amount, or
- The Medicare maximum allowable for services less the Medicare payment for providers who file institutional claims and a percentage of the coinsurance and deductible for providers who file professional and dental claims

- Medicaid will pay the lower of the copay or the Medicaid allowable for participants enrolled in Part C, the Medicare HMO.

Coordinating with DSS

For a person to get NC Innovations benefits, activities must be coordinated with the DSS Medicaid staff. A DSS contact person should be established for each NC Innovations recipient. The PIHP and the Care Coordinator work together with the person to get required information to DSS.

Coordination activities include:

- Referring a potential NC Innovations funding recipient to DSS is critical. This will allow a Medicaid application to be initiated if the person is not on Medicaid. For a person not receiving Medicaid, it will assure the person is in the proper category.
- Promptly processing (14 days for approval and up to 14 days to gather additional information if needed to resolve approval issues) the Individual Support Plan to obtain approval from the PIHP as quickly as possible is important for the person as well as DSS. DSS has strict time limits to act on Medicaid applications. If the Plan is not approved within the time limit, DSS may have to deny the Medicaid application. This means a person may have to reapply for Medicaid. Getting the ISP approved within the designated DSS and NC Innovations timeframes benefits the person.
- Coordinating deductibles helps participants. If the person has a deductible, work with the DSS Medicaid staff and the person/responsible party to be sure that there is a clear understanding of what may be used to meet the deductible, what proof is required for expenses, and who will get the proof to DSS.
- Notifying DSS about NC Innovations changes is necessary to be sure that the person receives the proper benefits and is given the proper notices about changes in Medicaid eligibility.
 - a. If the person has a deductible, DSS needs a copy of the current Individual Budget to know what expenses may be used for the deductible.
 - b. If the person is being terminated from NC Innovations, the timing of the termination must be coordinated with DSS. DSS has advance notice requirements that it must meet.
- See Chapter 16 for information about applicable Appeal Rights.

Also, it is helpful for the Care Coordinator to receive copies of the notices that DSS sends to the participant. This alerts the Care Coordinator to possible changes in Medicaid eligibility as well as any problems that DSS is having in processing applications and recertifications. DSS will need the person's permission to send the PIHP copies. The Care Coordinator should discuss this possibility with the NC Innovations recipient or his/her legal representative to obtain their permission.

Access to Care and Slot Management

Individuals access the NC Innovations Wavier through the uniform portal process. Individuals contact the PIHP under contract with the Division of Medical Assistance in the county where they live. If the individual's Medicaid originates from a county other than the county where they live, the PIHP refers the individual to the appropriate PIHP or LME (if the LME is not a PIHP).

Screening, Application Process, and the Registry of Unmet Needs

Individuals make application for the NC Innovations waiver by contacting the PIHP. PIHP procedures are followed. The procedures include assistance to any individual or person assisting the individual in, at a minimum, accessing the PIHP toll free number, staffed 24 hours per day, 7 days per week, 365 days per year for telephonic assessment and assistance in making referral/application for needed services. Procedures are followed uniformly for all individuals requesting or presenting as potentially eligible for NC Innovations Services. The time and date of the initial contact with the PIHP is recorded. The date and time of the referral are needed in the event the individual is determined potentially eligible for NC Innovations Services and is placed on the Registry of Unmet Needs (waiting list). If funding is not available for needed NC Innovations services at the time of application, the person is assessed for all other appropriate services and receives these or waits until funding becomes available. If the individual has Medicaid the individual receives any medically necessary Medicaid service.

The PIHP screens individuals for potential eligibility for the NC Innovations Waiver, which is intended to be the preliminary determination of an individual's potential eligibility for services based on the waiver eligibility criteria and need for waiver services. The screening process consists of

- a comprehensive clinical review
- other assessments as determined by the PIHP
- the administration of the NC Innovations Risk/Support Needs Assessment to determine whether the waiver can meet the individual's needs, and
- The Supports Intensity Scale is administered at a minimum prior to the Initial Individual Support Plan Development.
 - The NC SNAP is administered if the SIS ® has not been implemented by the PIHP.
 - The PIHP may include the administration of the SIS ®/SNAP in the screening and application process for NC Innovations.
 - The PIHP may include the administration of the SIS ®/SNAP during the time the individual is on the Registry of Unmet Needs.

If health or welfare 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. The PIHP clinical director (M.D. or Ph.D.) reviews the assessments of any individual who appears to not be eligible for the waiver, including those individuals who appear to have needs that cannot be met within the waiver cost limit and makes the final determination. Individuals who appear to meet the ICF-MR/DD Level of Care criteria whose needs cannot be met on the waiver are referred for ICF-MR placement. Written notification of the outcome of the assessment is provided to the individual.

Prioritization and Registry of Unmet Needs

If the individual is determined potentially eligible for waiver funding and funding is not available at the time of referral, the individual will be placed on the Registry of Unmet Needs. The PIHP maintains a Registry of Unmet Needs (waiting list) for individuals who are in need of NC Innovations Waiver funding. Individuals on the Registry of Unmet Needs are also referred to other resources while they are waiting for waiver funding. The time and date of the initial contact with the PIHP is recorded on the Registry of Unmet Needs and is used for determining the order of entrance to the NC Innovations Waiver. Should an individual's Medicaid eligibility transfer to another PIHP the date and time listed on the original PIHP's Registry of Unmet Needs will be transferred to the new PIHP's registry of unmet needs. PIHP's provide a report on the Registry of Unmet Needs (waiting list) to DMA and DMH/DD/SAS.

Slot Management

The number of individuals served during a waiver year is an unduplicated count. A person is counted against the annual allotment once the individual is entered into the Medicaid eligibility system as a NC Innovations participant. The person continues to count as one participant if he or she leaves and re-enters the program during the same Waiver year. The NC Innovations Waiver reserves a portion of the participant capacity for:

- Transitioning individuals from CAP-MR/DD to NC Innovations,
- When individuals are aging out of the CAP-C waiver,
- Emergencies,
- Military Transfers,
- Money Follows the Person,
- Community Transition for Institutionalized Children aged 17 and younger

The total number of slots and reserve capacity is current as of June 22, 2012. This slot information will be updated in the next technical amendment to reflect the addition of the remainder of the PIHPs into the Innovations Waiver.

NC Innovations is approved to allow the following number of participants

Year One: 625
 Year Two: 635
 Year Three: 670
 Year Four: 2081
 Year Five: 4461

Reserved Capacity (numbers are statewide, not per PIHP)

Reserved Capacity for Military Transfers

Year One: 0
 Year Two: 0
 Year Three: 0
 Year Four: 2
 Year Five: 7

Reserved Capacity for Money Follows the Person:

Year One: 0
Year Two: 0
Year Three: 0
Year Four: 10
Year Five: 26

Reserved Capacity for Community Transition for De-Institutionalized of Children Aged 17 and younger

Year One: 2
Year Two: 2
Year Three: 2
Year Four: 6
Year Five: 14

Reserved Capacity for CAP C Waiver Transitions and CAP-MR/DD Waiver Transfers

Year One: 10
Year Two: 10
Year Three: 5
Year Four: 37
Year Five: 82

Emergency Capacity

Year One: 10
Year Two: 10
Year Three: 10
Year Four: 18
Year Five: 18

DMA allocates a number of slots and a specific number of reserved capacity slots to each PIHP. Military Transfers are maintained and managed by DMA. Each PIHP submits a report to DMA by the 10th day of the following month on the status of the use of slots and reserved capacity slots in a format provided by DMA.

When an individual's county of Medicaid origin changes from a PIHP county to a county within another PIHP as confirmed by DSS, the individual's NC Innovations slot moves with the individual to the receiving PIHP. This is reported on the monthly report to DMA.

When Reserved Capacity is available, individuals who meet the criteria for Reserved Capacity slots will have first come first serve access to those slots. Individuals, who do not access NC Innovations through the reserved capacity slot process, access the waiver based on their date of referral (first come, first served basis). Funding is distributed on a per capita basis, geographically among the subdivisions of the PIHP areas (counties). Within the subdivisions, the waiver funding is distributed by date and time of referral. If a specific subdivision has no referrals, the unused waiver slots are reallocated among the remaining sub divisions of the PIHP based on the per capita equitable division of individuals waiting.

The PIHP determines if an individual meets the criteria for a reserved capacity slot. Reserved Capacity slots are managed in order of date that the request is confirmed to meet the criteria for the Reserved Capacity request. DMA is notified if an individual meets the criteria for a reserve capacity slot and the PIHP does not have a slot for the individual. If after consultation with DMA, there is no available reserved capacity slot, the PIHP provides the individual/legally responsible person with the PIHP grievance process if the individual is not eligible for Medicaid. If the individual has Medicaid, the individual is given Appeal Rights.

Reserved Capacity Criteria and information about the process for accessing the type of Reserved Capacity is located on the next page.

Type of Reserved Capacity Slot	Criteria	Other Information
Movement Between Waivers CAP-MR/DD to NC Innovations; CAP-C to NC Innovations when Aging out of CAP-C	*The date that the individual's county of Medicaid origin will change from a CAP-MR/DD county to a county within the PIHP area is confirmed by DSS *The individual is currently participating in CAP-C and will be aging out of CAP-C within the next six months. Transition from CAP-C may occur when the participant ages out of the CAP-C Waiver and meets the eligibility criteria for NC Innovations	A NC Innovations Level of Care and ISP must be completed for individuals transitioning from CAP-MR/DD or CAP-C to NC Innovations
Emergencies	A person is considered to have emergency needs when the individual meets the following 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 of more of the following criteria: • 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. • 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 the custody of the agency. • The individual requires protection from confirmed abuse, neglect or exploitation as documented by the Department of Social Services	*A clinical team inclusive of at least one of the following: Medical Director (psychiatrist) or the DD Clinical Director and a minimum of one developmental disability specialist, assesses the emergency situation
Military Transfers	Military Transfer Reserved Capacity Transfer Slots for individuals who were participating on a comparable 1915 (c) waiver in another state. The	Slots are requested from DMA once the determination is

	individual's family was transferred to NC for military service. The military transfer applies to active military personnel and only applies to reserved military personnel when they are being transferred related to military duties, as in they are being activated.	made that the individual is potentially eligible for NC Innovations and meets the criteria for the reserved capacity slot. Requests and responses are written. Requests require the signature of a PIHP Manager.
Money Follows the Person	Individuals who meet the criteria for Money Follows the Person and choose to receive home and community based services will receive priority consideration for these reserved slots	
Community Transition for Institutionalized Children 0 to 17	Individuals who are ages 0-17 and moving from a state Developmental Center or Community ICF-MR facility to the waiver receive priority consideration for these reserved slots.	

Eligibility Criteria

A person with mental retardation (intellectual disability) and/or a related developmental disability may be considered for NC Innovations funding if all of the following criteria are met.

- The individual is eligible for Medicaid coverage as defined in Chapter 6.
- The individual meets the requirements for ICF-MR level of care as defined in DMA Clinical Coverage Policy 8E. Refer to Appendix E for the ICF-MR Criteria.
- The individual resides in an ICF-MR facility or is at high risk for placement in an ICF-MR facility. High risk for ICF-MR institutional placement is defined as a reasonable indication that individual might need such services in the near future (one month or less) but for the availability of Home and Community Based Services.
- The individual's health, safety, and well-being can be maintained in the community under the program.
- The individual requires NC Innovations services.
- The individual, his/her family, or guardian desires participation in the NC Innovations Waiver program rather than institutional services.
- For the purposes of Medicaid eligibility, the person is a resident of one of the counties within the NC Innovations PIHP regions. See Appendix V for a list of counties in the NC Innovations Waiver.
- Individuals who are **new** participants to the waiver effective April 1, 2010 must live in private homes or facilities with six beds or less that meet the Home and Community standards.
- A new participant is a person who was not enrolled in the NC Innovations waiver as of April 1; 2008. Participants transitioning with their respective LME/PIHP from CAP-MR/DD to NC Innovations are not considered new participants for the purposes of waiver eligibility. Chapter 13 contains information about facility size requirements for individuals who are not new participants to the NC Innovations Waiver.
- The individual will use one waiver service per month for eligibility to be maintained.

Waiver Slot Assignment to New Individuals

When an individual is assigned a NC Innovations slot, the PIHP:

- Notifies the individual/legally responsible person of the slot availability
- Provides the individual/legally responsible person with a copy of the NC Innovations Participant Responsibilities Form. The Participant Responsibilities Form is a document that contains important information that an individual who is receiving NC Innovations funding needs to know. The individual or legally responsible person is asked to sign the agreement at the time of entry into the waiver and each year the individual remains on the Waiver. See Appendix F for a copy of the document. The PIHP answers questions about the agreement. If the individual or legally responsible person refuses to sign the Individual Responsibilities Form, it is documented that the form was reviewed with the individual but they refused to sign the form, and a copy of the Agreement is mailed to the individual/legally responsible person by certified mail.
- Advises the individual/legally responsible person of their institutional alternatives under the Waiver. Their choice is documented on the Freedom of Choice statement found in the Individual Support Plan. Annually, the participant is provided their choice of ICF-MR residential (institutional) services or Innovations Waiver services and this choice is documented on the Individual Support Plan. The decision of the individual/legally responsible person may be changed at any time by notifying the Care Coordinator. Should the individual/legally responsible person decline participation in the NC Innovations waiver and choose placement in an ICF-MR residential facility based on the response to the Freedom of Choice form, the PIHP locates facility placement for the individual.
- Notifies individuals who are living in facilities or institutions rather than private homes of waiver policies about residential facilities, and that they must move to a private home or a facility that meets waiver requirements prior to receiving NC Innovations funding if their current residential facility does not meet waiver requirements.
- Individuals who are transitioning from CAP-MR/DD to NC Innovations with their respective PIHP's are presented with the Participant Responsibilities Form within 90 days of entry into NC Innovations. For Western Highlands and ECBH, DMA will determine an implementation schedule for the Form.

Level of Care Determination

An ICF-MR level of care (prior approval assessment) is required for any individual under consideration for the NC Innovations Waiver funding. The criteria for this waiver and that of ICF-MR institutional care under the State Medicaid Plan are the same.

A NC Innovations Level of Care must be completed for any individual moving from an ICF-MR Developmental Center or facility or any individual transitioning to NC Innovations from another Community Alternatives Waiver. The NC Innovations Level of Care is not completed for any individual transferring from another PIHP.

Individuals referred for NC Innovations waiver funding will have their level of care accessed by a psychologist/licensed psychological associate or primary care physician as appropriate. If the presenting issue is an Intellectual/ Developmental Disability or a condition closely related to an Intellectual/Developmental Disability a psychologist or licensed psychological associate completes the assessment. If the condition is cerebral palsy, epilepsy, or a condition closely related to one of these two disabilities, a primary care physician completes the level of care assessment. The PIHP is responsible for training psychologists, licensed psychological associates and primary care physicians on the use of the Level of Care Tool. The PIHP provides information to those individuals about the completion of the Level of Care Tool and where to return completed Level of Care forms.

Psychologists and Licensed Psychological Associates complete a standardized IQ test and an adaptive behavior assessment to obtain information to assess level of care. The PIHP determines which tests are acceptable to determine the level of care assessment. If current assessments are available, the Psychologist and Licensed Psychological Associate will complete an update of the information, if appropriate. Information obtained from the assessments is used to complete the North Carolina Innovations Level of Care Eligibility Determination tool.

The PIHP determines which tests are acceptable for level of care assessment. The Supports Intensity Scale is not an assessment that may substitute for the assessment by the psychologist or licensed psychological associate. Psychological evaluations greater than five years old for adults or greater than three years old for a child are not considered current for the purpose of Level of Care determination.

Primary Care Physicians complete the Medical Evaluation attachment to the Level of Care tool. Information obtained from the assessment is used to complete the NC Innovations Level of Care Eligibility Determination tool.

The medical evaluation and the NC Innovations Level of Care Eligibility Determination tool are forwarded to the PIHP. The PIHP reviews the information and verifies the level of care. Pending recommendation of level of care, the PIHP completes the final determination and authorization of Level of Care and Medical Necessity. If there is disagreement between the Psychologist, Physician and the PIHP, the Medical Director or Medical Director Designee for the PIHP makes the final determination. Directions for the completion of the Form are in Appendix E.

Psychologists and Licensed Psychological Associates are accessed through the PIHP provider network and well versed in Level of Care assessment to facilitate easy access to services and supports. Primary care physicians are assessable in each of the counties served by the PIHP. The NC Innovations Level of Care Eligibility Determination tool is not completed by an employee of the PIHP.

Initial Level of Care Processing and Timelines

The authorization of the North Carolina Level of Care Eligibility Determination is completed by the PIHP within 30 days of the date that the Psychologist, Licensed Psychological Associate, or Physician completes the Level of Care Assessment. When the participant's level of care is determined to meet the ICF-MR Level of Care criteria, the PIHP determines if funding is available through the NC Innovations Waiver. After completion of the Level of Care, the individual is referred to Care Coordination and

assigned a Care Coordinator. The Care Coordinator works with the individual, his/her family and planning team to develop an Individual Support Plan. The Care Coordinator sends the completed Individual Support Plan and all required documentation to the PIHP so that it is **received** no later than **60 days** after the Level of Care effective date. If the Plan is not **received** within the time limits, the Level of Care assessment will need to be updated to confirm that the Level of Care remains the same.

Slot Assignment and Level of Care Determination for Individuals Transitioning from Other 1915 (c) Waivers and Institutions

A person may receive funding from only one HCBS Waiver at a time. If a person is currently receiving funding from one of the other HCBS Waivers in the state, and makes application for the NC Innovations Waiver, the PIHP will verify participation in any other waiver program prior to the completion of the NC Innovations Level of Care Eligibility Determination assessment to allow for a smooth transition/termination from the prior waiver. Other HCBS Waivers in North Carolina are the CAP-Children Waiver (CAP-C); CAP-Disabled Adults Waiver (CAP-DA); CAP Choices, and CAP-MR/DD. The PIHP must remember that authorizing the ICF-MR level of care could result in termination from the CAP-C, CAP-DA (including CAP Choices) or facility based intermediate (ICF) or nursing based services (SNF). See Chapter 15 for information about individuals transferring to the NC Innovations Waiver from the CAP-MR/DD Waiver.

Second Opinion / Appeal Rights

If the psychologist, licensed psychological associate or physician determines that the individual does not meet the ICF-MR, eligibility criteria, the PIHP offers the individual the option for a second opinion. The “second opinion”/determination of the psychologist, licensed psychological associate, or physician as to whether the individual meets the ICF-MR eligibility criteria is final and is not subject to appeal. DMA is notified of individuals who are determined not to meet the level of care after the evaluation process is completed, including individuals who do not choose the option for a second opinion by the PIHP.

If the PIHP determines that the individual does not meet the ICF-MR eligibility criteria after reviewing the LOC determination by evaluating psychologist, licensed psychological associate, or physician, the individual is provided appeal rights. Any determination that the individual does not meet the ICF-MR eligibility criteria must include a review by and approval of the decision by the PIHP Medical Director. Along with issuing appeal rights, the PIHP notifies DMA of any decision that an individual does not meet the ICF-MR Level of Care.

Annual Re-evaluation of Level of Care

After the person’s eligibility is determined through the NC Innovations Initial Level of Care Process, a Qualified Professional will complete the annual re-evaluation. This activity is an integral part of Treatment Planning Case Management (Care Coordination) required activities. Pending recommendation of level of care, the PIHP will complete the final determination of the continued authorization of Level of Care and Medical Necessity. **If the Level of Care of the participant is questioned during the re-evaluation, the participant will be referred back to the full evaluation process to verify level of care and medical necessity.** The Qualified Professional cannot make

the determination that the participant no longer meets the ICF-MR Level of Care. See Section 10 for additional information about the Annual Plan, including the Annual Re-evaluation of the Level of Care.

Level of Care Changed by a Physician

If a participant's level of care is changed by a physician by the completion of a Level of Care Tool to Intermediate, Skilled, or Hospital Level of Care (FL-2), the PIHP is notified. The PIHP completes Termination Procedures as described in Chapter 15. The individual/legally responsible person has the right to request a second opinion from a physician. The most recent Level of Care decision is followed.

Level of Care Quality Assurance Procedures

DMA will oversee the Level of Care assessment process through a series of Performance Indicators and random sampling of level of care determinations and re-determinations completed by the PIHP. See Chapter 17 for details of the Quality Improvement processes for NC Innovations.

Use of One Waiver Service Per Month

North Carolina Innovations participants must use one waiver service per month to remain eligible for the waiver. They are notified of this requirement upon entry into the waiver. The participant's Individual Support Plan must contain at least one NC Innovations Service that can be provided each month. The participant's Care Coordinator, provider or other PIHP Department may discover a participant's non-use of waiver services. When this happens, the following process is followed:

- The PIHP sends a letter to the participant or legally responsible person, advising them that termination procedures may be initiated if the participant does not use a waiver service within the next 30 days. Circumstances that are known to exist regarding the non-use of services are noted in the letter. If the participant has already resumed services, they are advised that future non-use of services may result in termination from the NC Innovations Waiver. The letter is copied to the, the Division of Medical Assistance and the Care Coordinator.
- The Care Coordinator follows up with the participant or legally responsible person to provide assistance as needed.
- If the participant does not resume services within 30 days, the PIHP sends a second letter to the participant or legally responsible person that reminds them that termination procedures may be initiated if the participant does not use a waiver service within the next 30 days. The letter is copied to the Division of Medical Assistance and the Care Coordinator.
- If at the end of the 30 days after the second letter, the participant has not used a waiver service, the PIHP begins termination procedures. A written summary of the circumstances of the participant's non-use of waiver service is prepared for DMA. DMA and the PIHP jointly determine if the participant should be removed from the waiver. If the participant is terminated the participant or legally responsible person is given appeal rights.

If the participant continues to exhibit a pattern of non-use of waiver (two series of letters as described in the process with follow-up by the Care Coordinator), the PIHP discusses this with DMA. DMA and the PIHP may determine that the participant should be terminated from the waiver. The PIHP completes termination procedures based on this

determination. DMA is notified of any individual who is not recommended for ICF-MR Level of Care after the second opinion or of any individual who does not request a 2nd opinion. DMA also is notified of any individual who is denied ICF-MR Level of Care by a PIHP.

The PIHP has a procedure and system to track the non-use of waiver services. Letters that are used in the process are included in Appendix Z.

A participant who is removed from the waiver due to non-use of services may request to re-enter the waiver at the completion of any termination or appeal process. Participants/Legally Responsible persons may contact the PIHP to be placed on the Registry of Unmet Needs if no waiver funding is available at the time of application. If the contact occurs within the same waiver year, DMA is contacted and a plan for bringing that participant back on the waiver is developed. If the request occurs after the end of the waiver year, the participant follows the referral and prioritization processes described in this chapter.

If the non-use of waiver services is a result of a participant's hospitalization, placement in an ICF-MR facility, admission to a psychiatric facility, or incarceration in a correction facility, please refer to Chapter 15 rather than the Use of One Waiver Service Procedure. DMA is also notified about any terminations from the waiver based on these admissions/placements.

Individual Budgeting

All persons supported through the NC Innovations Waiver will have an Individual Budget as a component of their Individual Support Plan (ISP). The Individual Budget will represent the total cost of waiver services authorized in the Individual Support Plan. Participants who live in private homes can self-direct a portion of their Individual Budget or they may choose to self-direct the entire Individual Budget. Participants who live in residential programs may choose to self-direct some of the services they receive. The Individual Budget will contain both provider and individual and family directed services, depending on the needs and preferences of the participant. See Appendix C for a list of services.

Uniform Methodology for the Calculation of Individual Budgets and Participants' Right to Information

The budget calculation methodology is uniform for all participants in the waiver. Budget methodology will be open to public review through the policies and procedures of the waiver. Individual Budgets are reviewed as changes are made to the ISP; review occurs no less frequently than one time annually. Budgets are monitored for under and over spending through the use of service utilization data. If under-or-over expenditures are identified, the Care Coordinator works with the participant/legally responsible person to complete a budget modification if needed.

The Care Coordinator, as part of the Individual Support Plan development, explains the methodology for budget development, total dollar value of the budget and mechanisms available to the participant/legally responsible person to modify their Individual Budget. Upon entry to the NC Innovations Waiver, the participant also receives written information from the PIHP that explains the budgeting methodology. During the Individual Support Plan development process, all participants and families are offered an orientation to the benefits of participant-direction and information to assist them in meeting an informed decision concerning their ability/willingness to assume the added responsibility of choosing this option. Individuals and families who choose participant direction are required to participate in training to assist them in carrying out these responsibilities.

Determination of the Initial Individual Budget

All current CAP-MR/DD Comprehensive and Supports waiver participants that are transitioning to NC Innovations have an Individual Budget that is a projection of the funding needed to provide services and supports identified in the Individual Support Plan. The budget (cost summary) reflects a summary of the frequency and duration of each medically necessary service or support described in the current CAP-MR/DD Plan of Care. For these individuals the current approved CAP-MR/DD budget amount will become the new Individual Budget amount once transitioned to the PIHP.

The newly transitioned Individual Budget will be used until the needed information can be developed to implement the Support Needs Matrix Supports which is anticipated to be a minimum of 24 months. During this transition the Individual Budget will reflect base budget services and non-base budget services, to begin to educate individuals and providers on the budget concepts that will be used in the Support Needs Matrix.

Support Needs Matrix

The Support Needs Matrix is a system designed to standardize funding among participants who have similar support needs and ensure that funding is allocated in a fair and equitable manner. All participants funded through the NC Innovations waiver (once transitioned to the Support Needs Matrix) are assigned to one of four matrixes on the Support Needs Matrix.

Once the Support Needs Matrix is fully implemented, and in areas where it is currently operational, participants that are new to the waiver and entering it for the first time will develop their Individual Support Plan with needed Base Budget services which will become their prospective Individual Budget. The initial prospective Individual Budget is subject to approval by the PIHP.

Components of the Individual Budget

The Individual Budget represents a participant's current needs and is not an entitlement for an amount of funding for an indefinite period of time. The Individual Budget is reviewed no less frequently than annually by the PIHP.

The Individual Budget consists of two types of services; Base Budget services and Non-Base Budget (Add-On) services. Base Budget services are the core habilitation and support services in the waiver. Non-Base Budget services are preventative services, and equipment. Combined these services may not total more than the \$135,000 cost limit within the waiver.

Base Budget Services are:

- Community Networking Services
- Day Supports
- In-Home Skill Building
- In-Home Intensive Supports
- Personal Care
- Residential Supports
- Respite
- Supported Employment

Non-Base Budget, also known as Add-On Services are:

- Assistive Technology Equipment and Supplies
- Community Guide Services
- Community Transition Services
- Crisis Services
- Financial Support Services
- Home Modifications
- Individual Goods and Services
- Natural Supports Education
- Specialized Consultation Services
- Vehicle Modifications

Modification to Individual Budgets

All modifications to the Individual Budget are based on a revision/update to the ISP and approved by the PIHP. A modification to the Individual Budget is requested through the Care Coordinator when the participant has a newly identified need.

Individual and Family Directed Supports

In the event that a participant chooses to self-direct services, the participant-directed portion of their budget will be the annual amount contained within the established Individual Budget for those services which may be participant directed. The participant-directed budget is known as the Individual and Family Directed Budget. See Appendix C for list of services that can be participant directed. The Care Coordinator monitors expenditures from Individual Budget on a monthly basis through review of paid claims, review of service documentation, monthly monitoring visits with the participant, and review of the monthly reports from the Financial Support Agency or the Quarterly Reports from the Agency With Choice.

Role of the Care Coordinator

Care Coordination is focused on the individual as part of a population and in relationship to the overall system. Care Coordination originated in the health care system where it was focused on management of chronic diseases. Care Coordinators manage consumer care across the continuum of care, throughout various care settings, and work in conjunction with the person, providers, and others to improve outcomes for the individual and make the best use of health care dollars. This is both a risk management and quality management function which has a significant impact on both the management of resources and the quality of care for an individual.

Care Coordination is a hands-on strategic tool that enables PIHP's to assure consumer access to appropriate and ongoing care. Care coordination is a managed care administrative function that covers treatment plan development, referrals to services, monitoring for delivery of services, coordination of care across systems including health care, and monitors the health and welfare of the individual.

Care Coordinators who are employed by the PIHP are employed in a different department separate and apart from the PIHP department that reviews and makes prior authorization decisions on service requests. Care Coordination is also referred to as Treatment Planning Case Management. Treatment Planning Case Management differs from Utilization Management (authorization and plan approval/denial) because Care Coordinators have the capacity to intervene directly in access to care, continuity of care, and the assessment and treatment planning for individuals that are identified through population management strategies.

For individuals enrolled in the NC Innovations waiver, the hands on development of the Individual Support Plan enables the PIHP to more directly support a consumer's access to disability appropriate care, ensure that the person receives information on all available service options and providers, and that the plan includes an appropriate array of services that will meet the needs and goals of the individual

Special Needs Populations:

Special Needs populations are population cohorts defined by specific diagnostic, functional, demographic and/or service utilization patterns that are indicators of risk and need for assessment to determine need for further treatment. The PIHP is responsible for first identifying these individuals and then to intervene if it is determined that individuals need assistance in accessing assessment and medically necessary services. Care Coordination is a managed care tool that is designed to proactively intervene and ensure optimal care for Special Needs Populations. The NC Innovations population is a Special Needs Population.

The roles and responsibilities of the Care Coordinator (Treatment Planning Case Manager) include:

- Facilitating person centered planning to include convening the participant, the participant's family, key providers, the Community Guide, others, and developing the Individual Support Plan (ISP);
- Explaining the methodology for budget development, total dollar value of the budget and mechanisms available to the participant/legally responsible person to modify their Individual Budget;

- Obtaining input from the participant and/or significant others in the participant's life about the life planning process and seeking information in an effort to obtain needed services on behalf of the participant; not to duplicate services that are the responsibility of the Community Guide;
- Informing significant others about the participant's situation and the Care Coordinator's efforts on behalf of the participant with the consent of the participant/legally responsible person;
- Assessing and addressing participant risks to ensure that the participant's identified risks are addressed in the Individual Support Plan;
- Facilitating the service delivery process including the re-assessment of the participant's level of care and the annual re-evaluation of the participant's needs and services;
- Assisting the participant in selecting a service provider;
- Monitoring the participant's situation to assure quality care and the health, safety, and well-being of the participant as well as the continued appropriateness of services. This also includes the monitoring of the Individual Support Plan, Individual Budget, and monitoring and coordination of all providers of service.
- Identifying the need for a representative for the participant who desires to direct their own services and supports, and assuring that the representative meets established criteria;
- Ensuring that the ISP identifies how emergency back-up services will be furnished for workers employed by the participant/family, and coordinating the provision of on-call emergency back-up services;
- Recognizing and reporting critical incidents;
- Assisting with grievances when necessary;
- Addressing problems in service provision;
- Responding to participant crisis. If there is an emergency, the Care Coordinator ensures that participant needs are met and ensures that any updates to the Level of Care and Individual Support Plan are made and submitted to the PIHP, based on the changes in the needs of the participant.
- Assuring access to specialized assessments,
- Coordinating services with the participant's Community Care of North Carolina (CCNC) medical home.
- Arranging Medicaid services
- Providing an Orientation to Individual and Family Directed Supports and referring the participant to a Community Guide for training and support of self-direction rights, rules, and responsibilities.
- Referring the participant for Community Guide Services, as needed, to address participant needs in the areas of advocacy, the development of Social networks, the development of community connections and other functions defined in the Community Guide Service Definition.

Role in Service Delivery

The participant, legally responsible person, providers, and the Care Coordinator have a role in assuring that the proper services are delivered as planned to meet the participant's needs. The Care Coordinator has overall responsibility for coordinating NC

Innovations services with other supports the participant is receiving. The Care Coordinator does this through contacts with the participant, legally responsible person, the participant's Community Guide, and other members of the Individual Support Plan team. If the participant does not have Community Guide services and is having difficulty accessing community resources, the Care Coordinator updates the Individual Support Plan to include Community Guide Services

The participant/legally responsible person assists the Care Coordinator, providers, and planning team in arranging and coordinating services. This includes informing the Care Coordinator of changes in situation and/or needs, cooperating in scheduling services, and allowing required monitoring to occur.

Arranging Services

The Care Coordinator ensures that the authorized NC Innovations services in the ISP are implemented by working with the participant and/or the legally responsible person, and the providers selected by the participant. If the participant and/or legally responsible person need assistance locating a provider in the PIHP Network, the Care Coordinator assists them by following the process in Chapter 4. Services are arranged to meet the participant's needs, and not for the convenience of providers. The participant/legally responsible person and the providers should agree on how services will be delivered. When scheduling services, the Care Coordinator, participant/legally responsible person, and planning team need to be aware of the service limitations in Chapter 13. Services are expected to be implemented promptly upon Individual Support Plan (ISP) approval. If services cannot be promptly implemented, the Care Coordinator, person/legally responsible person, and planning team consider the need for revising the ISP to meet the participant's needs. Chapter 10 describes the process for revising the ISP.

The Care Coordinator also informs the participant and/or legally responsible person of the option to self-direct services. The Care Coordinator offers an orientation to Individual and Family Supports at the time the Initial ISP and Annual ISP's are developed. The processes in Chapter 5 are followed if the Individual and Family directed option is elected.

Arranging Community Guide Services

The Care Coordinator refers the participant for Community Guide Services if the participant needs support in the areas of advocacy, the development of social networks, the development of community connections and other functions defined in the Community Guide Service definition. Information about Community Guide Services is included in the written information provided by the PIHP at the time the individual enters the NC Innovations Waiver. The Care Coordinator invites the Community Guide to all planning team meetings and makes sure that other planning team members are the informed of the important service provided by the Community Guide, including the Community Guide's role as advocate for the participant

Monitoring

The Care Coordinator is responsible for monitoring the implementation of the Individual Support Plan and all other Medicaid services provided to the participant as well as the overall care of the participant. Services are implemented within **45 days of initial ISP**

approval. Monitoring will take place in all service settings and on a schedule outlined in the ISP.

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

- Verification that services are provided as outlined in the ISP,
- Participants have access to services and identification of any problems that may arise,
- The services meet the needs of the participants,
- That the back-up staffing plans are implemented,
- Issues of health and welfare (rights restrictions, medical care, abuse/neglect/exploitation, and/or behavior support plan) are addressed and that participants are offered a free choice of network providers and that non waiver services needs have been addressed.

Care Coordinator monitoring occurs monthly to include the following:

- Participants 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 welfare needs.
- Participants whose services are provided by guardians and relatives living in the home of the participant receive monthly face-to-face monitoring visits.
- Participants who live in residential programs receive face-to-face monitoring visits monthly.
- Participants who choose the Individual Family Directed Supports option receive face-to-face monitoring visits monthly.

For months that participants do not receive face-to-face monitoring, the Care Coordinator has telephone contact to ensure that there are no issues that need to be addressed. The Care Coordinator also ensures that services utilized do not exceed services authorized. If problems arise with specific service providers, the Care Coordinator works with the participant and/or the legally responsible person to either resolve the problems or select a new service provider.

The Care Coordinator monitors the participant's situation as stated on the ISP and in the waiver. Some participants may require more monitoring than others because of the intensity of their needs, the support available from responsible parties, or other factors. The monitoring schedule is to be outlined in the ISP, with the intent to verify quality of services, continued needs, and delivery of equipment and supplies. The Care Coordinator reviews the provision of services in the location they occur as provided versus authorized services and determines if those services are meeting their intended purpose. The Care Coordinator looks at the provider's performance; the participant's response to the service; and determines the need for adjustments in the service. Documentation of monitoring and the actions taken/planned because of the monitoring are recorded in the participant's record.

The Care Coordinator monitors for progress or lack of progress through observation, interview, and documentation review. Providers must make service documentation

accessible to the Care Coordinator for review. The Care Coordinator should pay particular attention to the “by when” or target dates for long range outcomes on the participant’s ISP and update if billing is to continue beyond the projected target date. Billing may not occur for outcomes/goals that the participant has attained unless there is justification for billing as a maintenance outcome/goal.

Participant and Provider Responsibilities in Care Coordination Activities

The participant/legally responsible person and their providers must allow the Care Coordinator to have face-to-face contact with the participant as required in this Chapter and as documented in the ISP. If the participant/legally responsible person refuses the contact and/or monitoring, services may be suspended after consultation with DMA. In such instances, the person/legally responsible person may appeal the decision. See Chapter 16 for Appeals related to suspension or termination of services. The Care Coordinator is required to monitor NC Innovations services in all settings where services occur. The participant, legally responsible person, family, and/or provider must allow access to all settings where services are provided.

Coordination of Services, Including Other Service Providers

Service coordination involves the coordination of the services in the ISP, linkage with other services and resources available in the community, and monitoring of the work of the Community Guide. See Community Guide definition in Section 13 for clarification of services provided by the Community Guide.

- North Carolina Innovations Services: Most of the coordination and implementation of these services occurs as the ISP is developed and services are arranged. The Care Coordinator plans services to provide a workable array of services and supports for the care and treatment of the participant. The Care Coordinator continues this process as the person participates in planned service delivery. The Care Coordinator works with the participant/legally responsible person, providers, and others involved with the participant's care and treatment to avoid/resolve scheduling conflicts, duplication of effort, and other problems that hinder effective care. The Care Coordinator is accessible to all of the parties and encourages the sharing of information, both written and verbal. All involved parties need information to provide quality care. The Care Coordinator does not duplicate the duties of the Community Guide.
- Though the Care Coordinator does not control the provision of other Medicaid services, the Care Coordinator must be aware of other services being provided and how these services are being provided. The Care Coordinator works with others involved with the participant to help assure proper care and treatment, prevent duplication of services, and coordinate the services with the NC Innovations services. The Care Coordinator reports any problems or concerns about a service to the responsible provider. The Care Coordinator also assists the participant/legally responsible person in working with the providers. The Care Coordinator coordinates with the participant's CCNC medical home.
- The Care Coordinator maintains contact with the participant's Community Guide to assure that the participant has access to natural and community supports. The Care Coordinator also coordinates and promotes the use of natural supports in working with the participant's planning team. If the participant needs assistance with accessing and utilizing natural and community supports and does not have

Community Guide Services, the Care Coordinator updates the ISP to include this service.

Changes in Care

When monitoring reveals a change in the participant's needs, situation or condition, the Care Coordinator, along with the participant/legally responsible person and planning team, should consider changing the ISP. Possible changes must be discussed with the participant/legally responsible person and planning team. The team may also need to consult with other professionals. The instructions in Chapter 10 are followed if the ISP needs to be revised.

Should a participant require a different level of care and need to be referred to another 1915 (c) Home and Community Based Community Alternatives Program (CAP/DA/Choices or CAP/C), the transfer must be coordinated with the other waiver program. The same is true for participants transferring to NC Innovations from one of the other programs. Both the sending and receiving Care Coordinator need to keep each other informed of the status of the transfer and provide the terminating waiver program sufficient notice of approval for termination from the original program. A person cannot receive services from two Community Alternatives Programs at the same time.

Participants, who move out of the PIHP catchment area and their county of Medicaid eligibility becomes a non-NC Innovations county, will be referred to the Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD). Chapter 15 describes the referral process. The Care Coordinator works closely with the PIHP and staff from the NC Innovations PIHP or CAP-MR/DD Local Management Entity to assure that the transfer is timely and coordinated. Chapter 15 describes the process for transferring individuals who move to a county managed by in different PIHP.

Coordination with DSS Medicaid Eligibility

The Care Coordinator is responsible for verifying a person's continuing eligibility for Medicaid. The Care Coordinator coordinates Medicaid deductibles for the person with the participant/legally responsible person. The Care Coordinator must also be aware and respond to movement of the participant outside of the PIHP geographic area to ensure that changes in their Medicaid County of eligibility are addressed prior to any loss of service.

The participant must have an **"IN" indicator** in the Medicaid Eligibility System each month and maintain Medicaid eligibility in the PIHP catchment area, in order for NC Innovations services to be paid. The Care Coordinator is responsible for following up with DSS in the event that there are disruptions in payment due to the "IN" indicator not being present in the Medicaid Eligibility System.

Individual and Family Directed Supports

The Care Coordinator's role in the Individual and Family Directed Supports Option is described in Chapter 5 of this Guide.

Individual Support Plan Process

This section outlines the Individual Support Plan (ISP) process for participants. Certain activities must be completed to consider a person for NC Innovations funding and to assist them in obtaining and maintaining this funding source. Some of these activities must be completed at a specific point, while there is leeway in the timing of others. The following describes the key activities in the order that these activities normally occur.

Initial Individual Support Plans: Critical Time Limits and Dates

The PIHP/Care Coordinator keeps the following time limits and dates in mind when assisting a person in obtaining NC Innovations funding:

Level of Care Determination

The Level of Care Determination is completed as described in Chapter 7. The prospective participant must be a Medicaid applicant or recipient for the Level of Care Eligibility Determination Form to be processed. The Level of Care is usually approved by the PIHP before the Care Coordinator begins the ISP process.

A participant may receive funding from only one HCBS Waiver at a time. If the participant is transitioning from another waiver program to NC Innovations, it is critical that the PIHP/Care Coordinator work with the other waiver program to ensure that the transition to NC Innovations Waiver is coordinated.

If the person resides in an ICF-MR facility, it is necessary to ensure that coordination occurs in discharge planning for the participant so that the Level of Care Eligibility Determination is correctly completed for NC Innovations services at the time the person begins to receive NC Innovations funding.

Plan of Care Deadline

The 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. The ISP could need to be submitted sooner if DSS requires an approved ISP to meet a deadline process a Medicaid application, Coordination with DSS is necessary to ensure that the individual's Medicaid application is not denied. If denied the individual may need to re-apply for Medicaid.

North Carolina Innovations Effective Date

The effective date for NC Innovations participation is the latest of three dates:

- The Medicaid application date;
- The NC Innovations Level of Care approval date
- The date of deinstitutionalization

An individual may not enter the NC Innovations waiver prior to a participant's movement into a private home or facility that qualifies under the NC Innovations waiver. This is a facility with 6 or fewer licensed beds. The facility bed requirement of 6 or fewer beds does not apply to participants transitioning from CAP-MR/DD on the date their

LME/PIHP transitions to NC Innovations. Chapter 1 and 13 provide further explanation about facilities that NC Innovations' participants may live in, including an explanation of facility requirements to meet home and community characteristics.

Medicaid payment is available for NC Innovations beginning on the NC Innovations effective date if:

- The person is authorized for Medicaid on the date of service; and
- The service on the ISP is approved by the PIHP; and
- The participant/legally responsible person signs the ISP prior to the effective date

Participants Starting in a New Waiver Year

As the PIHP/Care Coordinator plans to assist a participant in receiving NC Innovations funding for the new waiver year, April 1, they keep the following in mind:

- If the participant is from the community, the PIHP approves the effective date of the level of care to be effective April 1 or later.
- If the participant is to be deinstitutionalized, April 1 is not a critical date for the Level of Care approval for deinstitutionalized individuals, as the Level of Care date does not determine the NC Innovations effective date. The NC Innovations effective date is the date of deinstitutionalization.
- Medicaid cannot pay waiver services provided before April 1.
- The special Medicaid eligibility considerations for NC Innovations participants cannot apply to the participants prior to April 1.

Discussing Initial Program Availability

After waiver funding is available for the prospective participant, the PIHP informs the participant and/or the legally responsible person for the participant of the availability of the funding source. The PIHP reviews the eligibility requirements, services and limitations as well as the needs and expectations of the participant and responsible party. The PIHP explains what the funding source can and cannot be expected to provide in relation to the participant's needs. The PIHP inquires about other insurance coverage that the participant may have. If the participant has other insurance, the PIHP notes this so that information about services covered by the other insurance policy, including percentage of payment can be obtained. The PIHP makes sure that the participant and/or the legally responsible person has written information about the NC Innovations Waiver.

As part of the discussion about program expectations, the PIHP documents the following:

- The PIHP informs the participant/legally responsible person of the choice between NC Innovations participation and ICF-MR placement and documents the choice on the Freedom of Choice Form. The Freedom of Choice between NC Innovations participation and ICF-MR placement is documented in the participant's record by the participant/legally responsible person signing the Freedom of Choice Statement located in Appendix I. The decision of the participant/legally responsible person may be changed at any time by notifying the Care Coordinator.
- The PIHP reviews the NC Innovations Participant Responsibilities Form with the participant/legally responsible person. The participant/legally responsible person signs and is given a copy of the form. The form is filed in the Participant's medical

record. See Appendix F for the Participant Responsibilities Form. See Chapter 7 for additional information about the Participant Responsibilities Form.

Medicaid Eligibility Referral

The process followed by the PIHP depends on whether or not the participant is a Medicaid recipient. The following guidelines are followed:

- If the participant is NOT a Medicaid recipient, the PIHP refers the participant to the county DSS Medicaid staff.
- If the participant already RECEIVES Medicaid, the PIHP notifies the Medicaid staff that the participant is being considered for NC Innovations. There are several types of Medicaid coverage that are not eligible for NC Innovations. The Medicaid staff must be aware of the possibility of NC Innovations to assure that any changes in coverage are processed. In some instances, a change in Medicaid coverage may be disadvantageous to the person/family; therefore, it is important that the person/family has the opportunity to be informed about the implications of a change. See Chapter 6 for details about Medicaid eligibility.

Level of Care

After the participant is referred to the county DSS or the Medicaid staff is notified of the NC Innovations application, the participant is referred for Level of Care determination. See Chapter 7 for additional information about the Level of Care and Appendix D for the Level of Care Form.

Assessment and Individual Support Plan

After the level of care is approved, the PIHP refers the participant to Care Coordination. Care Coordination assigns the Care Coordinator who initiates the person-centered planning process with the participant and the people he/she chooses to be a part of his/her planning team. An Individual Support Plan (ISP) is developed with the participant and his/her planning team. The assessment requirements are in Chapter 3 and the ISP requirements are in Chapter 4. The Care Coordinator explains to the participant, the legally responsible person, and the planning team that retroactive approval of NC Innovations services, supports, supplies and equipment is not allowed.

In order to allow the reporting of Treatment Planning Case Management prior to completion/approval of the ISP, the Care Coordinator must complete a written modified plan inclusive of the demographics page, action plan, and signature which identifies that Treatment Planning Case Management is to be provided on behalf of the participant.

Individual Budget

The Individual Budget is determined as described in Chapter 8. An Individual Budget Form is completed as part of the Initial ISP. See Appendix H for the Individual Budget Form.

Continuing Eligibility

As the ISP is completed/approved, the participant's Annual Plan due date is identified. As a participant is transitioned from the Initial ISP process to the Annual ISP system, care must be taken to make sure that the due date for the Annual ISP is identified and observed. It is possible that the first Annual ISP will be due very close to the Initial ISP due date as the participant's date of birth is the determining factor in scheduling the Annual ISP. The participant's Level of Care approval date and date of birth must be considered carefully in determining the first Annual ISP due date.

Annual Plan: Critical Time Limits and Dates

The Annual ISP includes a re-determination of ICF-MR level of care and completion of Assessments, a new ISP, a new Individual Budget, and that the Freedom of Choice statement in the ISP is completed. Every 12 months, the Care Coordinator completes an Annual Individual Support Plan (Annual ISP) to determine if the participant continues to meet criteria for ICF-MR level of care and remains appropriate for NC Innovations funding. If the participant's level of care is questioned, the participant is referred back to the full Level of Care process described in Section 7. The Care Coordinator may only verify that the participant continues to meet the ICF-MR Level of Care.

The Care Coordinator plans the Annual ISP so that the package is authorized during the birth date month of the participant. The birth date month is referred to as the "Annual ISP Month." The Care Coordinator sends the complete Annual ISP package to the PIHP so that it is received no later than the first day of the Annual ISP Month. The effective date of the Annual ISP is the first day of the month following the participant's birth date. If the Annual ISP is not completed on time, the participant could be terminated from NC Innovations.

Example: The participant's birthday is 7/15. July is the Annual ISP month for the participant. Each year, the Care Coordinator (Qualified Professional in Developmental Disabilities) completes the Annual ISP so that, the completed Annual ISP package is received by the PIHP July 1, the first day of the birth month. The effective date of the Annual ISP is August 1.

Level of Care Recommendation

The Level of Care Re-determination Section of the ISP should be completed to support the participant's continued need for ICF-MR level of care. A Care Coordinator (Qualified Professional in Developmental Disabilities) recommends and signs the Level of Care Re-determination section in the ISP prior to the participant's planning meeting. The Recommendation is signed no earlier than 60 days prior to the effective date of the Annual ISP. The Level of Care Re-determination Form is never completed after the birth date month.

Assessments

The Care Coordinator coordinates reassessments with the participant and his/her planning team. Refer to Chapter 3 for the content of the assessments, time limits for the evaluations, and documentation requirements. The assessment of risk is completed annually.

Individual Support Plan

A new ISP is completed by following the directions in Chapter 4 and The Individual Support Plan Manual. Services and supports are added, changed, and deleted according to the participant's current situation.

Individual Budget

The Individual Budget continues in the same amount as set in the participant's previous waiver year and as described in Chapter 8. The participant may request a modification to his/her budget as described in Chapter 8. An Individual Budget Form is completed as part of the Annual ISP. See Appendix H for the Individual Budget Form.

Revisions to the ISP: Critical Time Lines and Dates

Person-Centered Planning is a dynamic process, and should contain review and revision of the plan as often as the participant's life circumstances change. Assessments are also updated whenever the participant's situation changes. After a participant begins receiving NC Innovations funding, the Care Coordinator monitors the treatment, services and supports the participant is receiving, and makes changes when a new need is identified. The Care Coordinator's close contact with the participant/legally responsible person, providers, and others involved provides indications of any need to change treatment, services or supports. When changes are needed, the Care Coordinator, with the participant and the participant's planning team, determines if the ISP needs to be revised or if termination should be considered.

The Care Coordinator also reviews the ISP at a minimum frequency based upon the target date assigned to each long range outcome. This includes a review of the outcomes to determine if the outcomes are met, are on-going and a new target date assigned, or if the goal has been discontinued and why. This Section explains when an ISP revision is required and how to complete a revision.

Required Action on Changes

The action needed depends upon the nature of the change. Changes in the ISP may not result in the participant's Individual Budget exceeding \$135,000 per participant plan year or the Limits on Sets of Services

Change in Cost

When the cost of a service changes, the Care Coordinator recomputes the Individual Budget. The Individual Budget will be adjusted to reflect the change in the cost of the service. The PIHP will notify the Care Coordinator of the new Individual Budget amount. The Care Coordinator notifies the participant and/or legally responsible person of the change in the Individual Budget. Approval of the PIHP is not required.

Change in Amount, Duration or Frequency of Service

When a service is to be added, deleted or changed in amount, duration, and/or frequency, the Care Coordinator revises the plan **EXCEPT** when the change is due to one of the following reasons:

- Temporary, one-time change in approved services: a one-time change in an approved service that does not require a new service authorization usually does not require a plan revision. An example of a situation which fits this category is the suspension of Day Supports for a short period at the request of the participant and family during a vacation period. Another example is when a provider is temporarily not available and the absence of the provider does not endanger the participant. In this situation, the planning team and/or responsible caregiver assure adequate coverage by other sources which are included in the back-up staffing section of the ISP. The participant's planning team should use common sense and discretion in applying this exception, and **document an explanation of the circumstances in the participant's record**. The services identified in the ISP were established as a means of preventing institutionalization and to meet the health, safety, and welfare of the participant. **Failure to implement the ISP as written indicates the participant's needs are unmet and that he/she may be at risk.** The provider agency, Employer of

Record or Agency With Choice, follows the PIHP Incident Reporting Procedure for Back-Up Staffing as described in Chapter 17.

- Supply variations within estimate: The amount used may vary from the estimate due to minor changes in the participant's condition. The Care Coordinator does not have to revise the Plan if the pattern of use remains within the estimate on the ISP. The ISP must be revised if the exceptions become a recurrent pattern,

Preparing the Revision

The ISP is revised by completion of the ISP update page. The Revised ISP must contain the signatures of the participant/legally responsible person and the Care Coordinator. See Chapter 4 and The ISP Manual for instructions on completing the Update Page of the ISP. Plan revisions must have the approval of the PIHP before Medicaid reimbursement is authorized.

An Individual Budget is completed for each revision to the ISP. If the participant requests services that exceed the Individual Budget, the Care Coordinator assists the participant in requesting a modification to his/her Individual Budget. See Chapter 8 for Modifications to Individual Budgets.

Other Changes to the Plan of Care

The ISP is also revised as long-range outcomes change or are met. Provider Agencies, Employers of Record and Agencies With Choice develop short-range goals and strategies with the participant/legally responsible person to implement the long-range outcomes in the ISP. The short-range goals and strategies do not require the approval of the PIHP.

Individual Support Plan Approval and Service Authorization Process

See Appendix L for additional information about the PIHP Plan of Care Review Process.

If the participant/legally responsible person accepts the plan and the plan appears to meet NC Innovations criteria, the ISP or revision to the ISP and other required information are submitted to the PIHP. Approval of ISPs or revisions to ISPs occurs locally at the PIHP following a process approved by the Division of Medical Assistance (DMA).

If an ISP is not submitted with an authorized signature (individual or legally responsible person) by the expiration of the participant's current ISP, the participant becomes ineligible for continued NC Innovations Services. The PIHP terminates the participant from NC Innovations and issues Appeal Rights to the participant/legally responsible person. DSS is notified and may terminate the individual from Medicaid if the individual's Medicaid is contingent upon NC Innovations Waiver Participation. If the person wishes to re-enter the Waiver in the same Waiver Year, the procedures for a New Waiver Participant's entry into NC Innovations are followed, including obtaining a new Level of Care.

PIHP Individual Support Plan approval staff have extensive expertise in practices/interventions in the field of developmental disabilities. They are trained in the use of clinical practice guidelines developed by the PIHP, person centered planning, risk planning, level of care determination, assessment, best practice in developmental disabilities, and the requirements of the waiver. Their primary function is to make plan of care approval and authorization decisions by conducting initial, continuing, discharge and retrospective authorizations of services. The work is accomplished through the consistent and uniform application of the PIHP's Clinical Criteria to each participant's needs to determine the appropriate type of care, in the appropriate clinical setting.

Information Needed for Individual Support Plan Approval and Service Authorization

Minimum information required for Individual Support Plan approval is:

- Initials: Contact information for the Care Coordinator; Individual Support Plan, including the Freedom of Choice Statement; Individual Budget; Initial Level of Care Assessment and the Supporting Evaluations, as applicable; the Risk/Support Needs Assessment; the Supports Intensity Scale or the NC SNAP; additional assessments; Behavior Support Plan, if available; and needed physician orders
- Annual review: Contact information for the Care Coordinator; Individual Support Plan, including Freedom of Choice Statement and the annual reassessment of the Level of Care; Individual Budget; the Risk/Support Needs Assessment; the Supports Intensity Scale or the NC SNAP; additional assessments, as applicable; Behavior Support Plan, if available; or needed physician orders. For Annual ISP's, the PIHP completes the final determination for the continued authorization of Level of Care. If the Care Coordinator (Qualified Professional) or the PIHP questions the need for continued ICF-MR level of care, the process for completing an Initial Level of Care is followed as described in Chapter 7 and Appendix D.
- Revisions: Contact information for the Care Coordinator; the completed Update Page of the Individual Support Plan; and the revised Individual Budget; and if needed, evaluations to support requested services, inclusive of physician orders.

For Assistive Technology Equipment and Supplies; Home Modifications, and Vehicle Adaptations, the following additional information is required:

- A plan for how the participant and family will be trained on the use of the equipment.
- Statement of medical necessity by a physician (not required for repair).
- Shipping costs are included as long as they are itemized in the request.
- Other information as required for the specific equipment/supply request.
- When a written recommendation is required by an appropriate professional and a physician's signature certifying medical necessity, the PIHP determines if the physician's signature must be included on the recommendation or if it may be on a separate document.
- The PIHP determines the appropriate professional(s) that make written recommendations for services that require those recommendations.
- When quotes are required for purchases, the PIHP determines how many are required.

For Assistive Technology Equipment and Supplies, the following additional information is required:

- An assessment/recommendation by an appropriate professional that identifies the participant's need(s) with regard to the Equipment and Supplies being requested. The assessment/recommendation must state the amount of an item that a participant needs.
- Supplies that continue to be needed at the time of the participant's Annual Plan must be recommended by an annual re-assessment by an appropriate professional. The assessment/recommendation must be updated if the amount of the item the participant needs changes.
- Requests for Adaptive Car Seats require the following:

- Individuals must have a documented chronic health condition of developmental disability which requires the use of an adaptive car seat for positioning. Car seats will not be approved for behavioral restraint.
- Prior approval must be requested with the following information in the assessment:
 - o Participant's weight
 - o Weight limits of the car seat currently used to transport
 - o Participant has a seat to crown height that is longer than the back height of the largest child car safety seat if the participant weighs less than the upper weight limit of the current car seat. The measurements must be documented.
 - o Reasons why the participant cannot be safely transported in a car seat belt or convertible or booster seat for individual weighing 30 pounds and up.
 - o Certification of medical necessity, assessment requirements and price quotes as required by PIHP policy and NC Innovations Technical Guide

For Community Transition, the following additional information is required:

- A Community Transition Checklist. Required elements are in Appendix U.

For Home Modifications, the following additional information is required:

- Assessment/recommendation by an appropriate professional that identifies the participant's need(s) with regard to Home Modifications requested.

For In Home Intensive Supports, the following information is required:

- Assessment, and if indicated, a fading plan or plan for obtaining assistive technology to reduce the amount of In Home Intensive Supports need by the participant.

For Vehicle Adaptations, the following additional information is required:

- A recommendation by a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation.
- The recommendation must contain information regarding the rationale for the selected modification, recipient, and pre-driving assessment if the participant will be driving the vehicle, condition of the vehicle to be modified, and insurance on the vehicle to be modified. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles and the family.
- If purchasing a vehicle with a lift on it, the price of the used lift on the used vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the participant/family may not take possession of the lift prior to approval by the PIHP Utilization Management Department.
- Evaluation by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications.

- The modification must meet applicable standards and safety codes. Care Coordinators should inspect the completed adaptation from a health and safety perspective.
- If paying for labor and costs of moving devices/equipment from one vehicle to another vehicle, then training on the use of the device is not required.

For Natural Supports Education, the following additional information is required:

- Long range outcomes directly related to the needs of the Participant or Natural Support's ability to provide care and support to the Participant is required.

For Individual/Family Directed Supports, the following additional information is required:

- An Individual/Family Directed Supports Assessment
- Representative Needs Assessment and Representative Designation/Agreement, as Applicable
- Verification of Training for Managing Employer and Representative, if applicable
- Individual and Family Directed Supports Agreement

Timelines for Individual Support Plan approval

Approval of Individual Support Plans will be completed in a timely manner. Review will be completed in 14 calendar days and result in one of the following actions:

- Plan approval/service authorization
- Plan pended for up to 14 calendar days
- Denial of request

Individual Support Plan Approval

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

- Gives the participant/legally responsible person written notification of the ISP approval, and a copy of the approved ISP, including the Individual Budget
- Gives written notification of the DSS Medicaid staff of Annual ISP approval, including a copy of the Individual Budget, if the participant has a deductible, and
- Ensures that the ISP is initiated and continues to monitor services
- See Appendix L for the elements of the Standardized Plan Approval Checklist.

Service Specific Information Required for Approval

Services are expected to begin within 45 days following approval of the ISP.

Individual Support Plan Disapproval

If the PIHP does not approve the ISP, the PIHP notifies the participant/legally responsible person in writing of the denial and the participant's appeal rights. The PIHP notifies the DSS Income Maintenance staff of the denial, once all appeals processes have been exhausted.

Oversight of Plan of Care Approval Process

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

Individual Support Plan Implementation

The implementation of the Individual Support Plan (ISP) is the shared responsibility of all members of the team. The participant directs the planning process and works on the goals established to reach goals in the ISP. The Care Coordinator shares information, monitors services and supports the participant receives. The provider of service ensures that staffing is provided, staff is trained and the provision of services is monitored.

Individual Support Plan Service Authorization

Provider agencies follow the PIHP authorization process located in the PIHP Network Provider manual. The provider agency receives a service authorization from the PIHP, which details the type of service that was authorized, the amount of service and the length of authorization. It is very important that the provider have a service authorization that matches the services that they are assigned to provide in the ISP. Providers must provide the service as specified in the authorization to receive reimbursement and as specified in the service definitions and limitations on sets of services. The PIHP has a procedure for sending the provider a copy of the approved ISP. This could include be through the Care Coordinator or other staff/department.

In Individual and Family Directed Supports, the Financial Support Agency or Agency With Choice receives the authorizations for services provided under this Option. The PIHP has a procedure for sending the Employer a copy of the approved ISP. This could include be through the Care Coordinator or other staff/department.

Timeline for implementation

Services are expected to begin within 45 days following approval of the Individual Support Plan. If there are delays in starting services, alternative sources of care should be considered. The participant's record must show the reason for the delay and document the actions taken to assure proper care. If services cannot begin promptly, the Care Coordinator determines whether the ISP can be revised to meet the participant's need. If the ISP can be revised, an ISP revision is submitted to the PIHP. If it is not possible to meet the participant's needs, termination procedures are initiated.

Development of Outcomes and Strategies

The development of achievable short-range goals which are the steps taken to accomplish the long range outcomes outlined in the ISP are critical to the participant's ability to successfully meet those outcomes. Provider agencies, Employers of Record and Agencies With Choice develop the short-range goals. In addition to short-range goals, the provider is responsible for the development of the steps or strategies to meet each goal plan. Strategies/interventions/task analysis should be written at the level of detail to support the short-term goals. See Chapter 14 for additional information about the documentation of short-range goals and strategies.

Plan Monitoring

Provider agencies, Employers of Record and Agencies With Choice are responsible for monitoring the implementation of the ISP through clinical oversight and supervision of staff. This supervision includes ensuring that staff has implemented outcomes consistently using the strategies outlined for them, to meet the unique needs of each participant. To assist in monitoring progress toward goals, the provider agency, Employer of Record or Agency With Choice completes a review of the progress the participant has made toward achieving the short-range goals. For specifics on

documentation, see Chapter 14. If progress has not been made, the provider, Employer of Record or Agency With Choice works with the participant to revise the short-term goals or strategies to meet the needs of the participant. The Care Coordinator monitors as outlined in the ISP and revises long range outcomes, as needed.

Strategies to Address Risks and Crisis Plans

Provider Agencies, Employers of Record, and Agencies With Choice implement strategies to address risks and the Crisis Prevention Plan that are included within the ISP. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). The ISP states who and how risks will be monitored including the paid providers, natural and community supports, participants and their family, and the Care Coordinator. Strategies to mitigate the risk reflect participant needs and include consideration of the participant preferences. Strategies to mitigate risk may include the use of risk agreements/behavior contracts. The Care Coordinator is notified if the Individual Support Plan or crisis plan needs to be revised.

Back-Up Staffing

All Participants will have a back-up staffing plan outlined in their ISP. The Back-Up Staffing Plan is designed to meet the needs of participants to make sure that their health and safety is assured. It outlines who (whether natural or paid) is available and their contact numbers. At least two levels of back-up staffing are identified for each waiver service provided. The back-up plan will detail if staff that is available for backup are paid or unpaid and any specialized training the back-up staff would need to ensure health and safety until other staffing could be arranged. If a provider agency or Agency With Choice provides the services, it will be their responsibility to ensure that back-up staff is available in the event that the regularly assigned staff person is not available. If participants have individual services rather than group services, the back-up staffing plan will provide for Individual back-up staffing.

Participants who choose the Individual/Family Directed Supports Option also need to make arrangements for back-up staffing. In the event that the planned back-up staff person does not arrive to assist the individual, the Employer of Record has information available to contact a designated agency contracted with the PIHP to provide back-up staffing who can send staffing until other arrangements can be made. Managing Employers contact their Agency With Choice if the planned back-up staff person does not arrive to provide service.

Failure to provide back-up staffing is considered a Level 1 Incident. A Back-Up Staffing Incident Report Form, located in Appendix S, is completed by the Provider Agency, Agency With Choice, or Employer of Record and submitted to Quality Management. Chapter 17 provides further information about Back-Up Staffing Incident Reporting Procedures.

Use of Monthly Waiver Service

Participants are required to use a waiver service monthly. Failure to use a waiver service monthly is reported to the PIHP. Participants who do not use a monthly waiver service may be terminated after consultation with DMA from the NC Innovations Wavier.

Chapter 7 provides additional information about the use of a monthly waiver service.

Provider Agency Role and Responsibilities

The North Carolina Mental Health/Developmental Disabilities / Substance Abuse Services Health Plan (1915 (b) (c) concurrent waiver inclusive of the NC Innovations Wavier), as a managed care waiver, allows for a waiver of “freedom of choice”. This means that the PIHP can determine the size and scope of the provider network. This wavier of “freedom of choice” is congruent with the PIHP’s responsibility under both waivers to ensure choice and accessibility of services. This is important to ensure economic viability of providers in the Network and to promote efficiency while at the same time ensuring that participants have a choice of providers. The primary goal of the PIHP Network is to ensure that participants have choice between providers who have or are developing experience in best practice and evidence based practices. The PIHP will establish and maintain an appropriate provider network that is sufficient to provide adequate access to all services covered through the NC MH/DD/SAS Health Plan, including NC Innovations.

Provider Network

All providers will be qualified and contracted through the PIHP to join the network. The network must have a sufficient number, mix and geographic distribution of providers to assure that necessary services for NC Innovations participants are delivered in a timely/appropriate manner in keeping with the Access standards. Providers available through the network will be culturally competent, demonstrate competencies in best practices/evidence based practices and outcomes, will ensure health and safety for the participants they serve and demonstrate ethical and responsible practices. Participant satisfaction and achievement of participant outcomes are high priorities of the PIHP network. Information regarding provider enrollment can be found in the PIHP Network Provider Manual.

Quality of Care

The PIHP is highly accountable to the Division of Medical Assistance for the quality of waiver services provided by the PIHP Network providers who deliver NC Innovations Waiver services. In addition to state requirements, Medicaid waiver requirements are extensive and include:

- Health and Safety
- Participant Rights Protection
- Provider Qualifications
- Participant Satisfaction
- Incident Management
- Assessment of outcomes

Specific requirements for Providers of North Carolina Innovation Services

Providers of NC Innovations Services will adhere to the following requirements:

- Provider agencies may not provide incentives, gifts or the expectation of savings within a budget in order to attract any participant or legally responsible person to enroll with their agency.
- Complete a Health and Safety checklist for any staff that provides Personal Care or Respite in the home of the agency staff person. This Checklist does not apply to staff providing services under the Relative as Provider Policy. See Appendix Q. The form is retained in the Providers Agency, Employer of Record or Agency

With Choice files. Additionally the Provider Agency Qualified Professional and/or Employer of Record / Agency With Choice Qualified Professional is required to monitor services in the staff's home monthly.

- Participate in the development of the participant's ISP including the updates.
- Recruit personnel who meet the requirements in Chapter 13.
- Implement the services authorized in the ISP.
- Develop, short-range goals, training interventions/task analysis/strategies for achievement of long-range outcomes in the ISP with the participant and or legally responsible person, and other planning team members that are appropriate.
- Assist in the coordination of services and communication with the participant/family.
- Monitor services authorized by the PIHP to ensure consistency with the ISP.
- Review and maintain adequate documentation of services making documentation available to Care Coordinators, the PIHP and others as needed.
- Notify the Care Coordinator about significant changes in the participant needs and service delivery.
- Submit Incident Reports to the PIHP per State Rule requirements and NC Innovation policy. Per NC Innovations policy Level 1 incident reports are completed for all failures to provide back-up staffing for services approved in the ISP.
- Monitor notes and billing to ensure integrity of all claims submitted to the PIHP for payment.
- Provide the services as specified in the provider agency's contract.
- Respond to emergencies of participants and have a back-up system in place to respond to emergencies/crisis on weekends and evenings as outlined in the NC Innovations service definitions. Providers of In-Home Intensive Supports, In-Home Skill Building, Personal Care, and Residential Support services are required to have QP staff available as Primary Crisis Services providers for emergencies that occur with participants in their care 24 hours per day 7 days per week or have an arrangement (memorandum of understanding) with a Primary Crisis Services Provider.
- Comply with policies and procedures outlined in the NC Innovations Waiver, NC Innovations Technical Guide, the PIHP Provider Manual, any applicable supplements to the Provider Manual and the Provider's Contract.
- Provide services in accordance with applicable state and federal laws.
- Document all services provided in Chapter 14 of this Guide and/or the DMH/DD/SAS Records Management and Documentation Manual.
- Ensure back-up staffing is available when the lack of immediate care would pose a serious threat to the participant's health and welfare and formal providers are not available. **If back-up staff is not available, the provider agency must complete a Level 1 Incident Report and submit to the Quality Management department. See Chapter 17 for Back-Up Staffing Incident Reporting requirements and Appendix S for the form.**
- Submit documentation required for verification of employment of relatives or legally guardians and adhere to disposition of the decisions made by the PIHP regarding this policy.
- Review all AFL sites using the PIHP AFL Checklist for health and safety related issues. See Appendix Y for the checklist.

Documentation

Provider Agencies are responsible for the development of short range goals and task analysis/strategies.

The task analysis is a process for determining in detail the specific behaviors required of staff to assist the participant with the implementation of an outcome. Task analysis is the analysis of how a task is accomplished, including a detailed description of any unique factors involved in or required for one or more people to perform a given task. For example: a task analysis would be used to assist a participant with a specific self-help or daily living skill.

A strategy is a long- term plan of action designed to achieve a particular outcome. Strategies are used to make a problem easier to understand and solve.

Free Choice of Providers

Participants will have free choice of providers within the PIHP network and may change providers as often as desired. If an individual's Medicaid changes to one of the counties within the PIHP region and is already established with a provider who is not a member of the network, PIHP makes every effort to arrange for the participant to continue with the same provider if the participant so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if a participant needs a specialized Medicaid service that is not available through the network, the PIHP arranges for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, participants are given the choice between at least two providers. Exceptions would involve institutional services or highly specialized services that are usually available through only one facility or agency in the geographic area. A listing of network providers will be made available to participants and their families for review. The Care Coordinator can assist the family to identify providers who have:

- Geographic Availability
- Cultural Specialty
- Disability Specific Specialties

Employment of Relatives/Legal Guardian as Providers

If during the recruitment process, a Relative/Legal Guardian living in the home of the waiver participant, applies for employment with a PIHP Provider Agency the Provider Agency must follow the process designated by the PIHP to review and approve this employment arrangement.

Questions to consider prior to hiring a relative or family member:

- Is this about the participant's wishes, desires, needs or about supplementing a family member's income?
- As an adult is it appropriate to still have mom and dad with the participant throughout the day?
- If a family member supports an individual from birth onwards into adulthood, does the individual learn to adapt to different people and increase he/she flexibility and independence?

- If a participant with a disability is always supported by a family member, what happens when that caregiver ages/dies? Who else has knowledge of the participant?
- Can a family member be a barrier to increased community integration or friendship development?
- Does having a family member as direct support staff expand the participant's circle of support or risk shrinking it?

North Carolina Innovations Services

The home and community based services provided through this waiver are intended to provide services and supports that are essential for participants to reside in and participate as members of their communities. The cost of waiver services cannot exceed the Individual Budget Limit except as described in the Individual Budget Methodology in Chapter 8 nor can services exceed the Limits on Sets of Services listed in Appendix M.

General Information on Use of Services

Services and supports will be determined through a person centered planning process and written in the Individual Support Plan (ISP). The use of NC Innovations Services is based on the needs of the participant, the preferences of the participant, the availability of other formal and informal personal resources and supports, and waiver regulations. The ISP is written from the participant's perspective rather than in terms of the availability of services in the waiver. Paid services that are needed in addition to natural and/or community supports are selected based on the participant's needs, and are not determined by the need to pay an agency or an employee a particular reimbursement rate. How much of each service a participant receives, how often it is being provided and how long it is provided must be included in the participant's ISP and approved by the PIHP. The following information applies to the use of the NC Innovations Services:

- NC Innovations Services may only cover the services defined in this Chapter and may only be used to provide services, supports, equipment and supplies in the service definitions approved by the Centers for Medicare and Medicaid Services (CMS).
- Payment will not be made for services, supplies and equipment received prior to the authorization by the PIHP.
- Participants, legal guardians, and family members **may not receive NC Innovations funds** unless the legal guardian or family member is receiving reimbursement as an employee of an agency, Employer of Record, or Agency With Choice in accordance with specifications in this Chapter.
- The services defined in this Chapter do not address any named technique or therapy. These definitions have been written to meet general best practice habilitation and support principles and not to approve/deny any type of training and/or support. The decisions regarding techniques should be based on the needs/preferences of the participant, the development of the ISP, the PIHP DD Practice Guidelines, the approval of the ISP, and in the end the conditions of waiver participation. The DMH/DD/SAS Client Rights Rules must be followed. Experimental techniques and therapies are not reimbursed under these definitions.
- For services that have a group rate where a potential group exists, the expectation is the participant receives group services unless there is justification in the participant's ISP that individual services are necessary to meet the disability specific needs of the participant. When the group rate is authorized, then that rate is billed regardless of the attendance of other participants in the group. Individual services are always moved to group, as appropriate for the participant, for services that have a group rate. The size of the group is based on the needs of the participant.

- Providers (both agencies and direct service employees) who accept Medicaid payment may not charge participants or their families any additional payment for services, supports, and/or equipment billed to Medicaid. This applies to all NC Innovations and Medicaid services and equipment. Participants and their families cannot pay part of the cost of the service or equipment.
- Provider agencies and Agencies With Choice may not require a waiver participant or their family to sign an agreement that they will not change Provider Agencies as a condition of providing services to the participant.
- Provider Agencies and Agencies With Choice follow requirements in ASPM 45-2 for updating required employee background checks and certifications. Employers of Record state in the ISP how they intend to update background checks and certifications.
- Some tasks performed for a participant by a provider require assessment by a nurse of the employee's ability to perform the task and supervision by a nurse regardless of the Waiver qualifications. The North Carolina Nursing Board must be consulted if there is any question about the safety and appropriateness of an employee to perform a task for a participant.

General Limits on Services

The following general limits apply to all NC Innovations Waiver Services:

- In all cases services under this waiver are secondary to services available through the State Medicaid Plan under Title XIX.
- Cost limits for services apply to the participant's annual planning year with the exception of Assistive Technology: Equipment and Supplies; Community Transition Supports; Home Modifications; and Vehicle Adaptations. These services have limits over the duration of this waiver (five years).
- Payment for NC Innovations Services will not be made for a person who is a patient of a hospital, nursing facility, or ICF-MR facility or a person who is incarcerated in a correctional facility.
- Participants in this waiver receive Treatment Planning Case Management Case Management through Care Coordination.
- The amount of services is subject to the participant's Individual Budget as specified in Chapter 8 and the limits on the number of hours of service as specified in Appendix M.

Services Provided to Participants Eligible for Educational Services

NC Innovations Services are not to be used as a replacement for educational services funded under IDEA. The following policy applies to school-aged participants:

- NC Innovations Services are offered outside of school operational hours, and are defined as the documented hours of the school system for the grade the child would attend.
- Children who are home-schooled can receive Waiver services outside of their documented home school schedule. The NC Department of Public Instruction:
 - defines a home school as "a nonpublic school in which one or more children of not more than two families or households receive academics from parents or legal guardians, or a member of either household."

- expects a home school to operate on a regular schedule for at least nine calendar months excluding reasonable holidays and vacations.
- provides the parent or legal guardian of a waiver participant who is participating in a home school with verification of the receipt of the Notice of Intent to Operate the Home School from DPI/Division of Non-Public Education or an "Inspection Verification Certificate" from DPI/Division of Non-Public Education.
- The family of children who are home schooled must present the verification of the receipt of the Notice of Intent to Operate the Home School from DPI/Division of Non-Public Education, an "Inspection Verification Certificate," or other verification from DPI/Division of Non-Public Education and home school schedule to the Care Coordinator to assist in developing the Individual Support Plan. If the family does not provide the home school certificate and schedule then the first bullet applies.
- Children who are homebound for any part of the school day can receive NC Innovation Services outside of the hours of school operation documented in their Individual Education Plan, provided that the hours do not duplicate educational services provided by the school system (ancillary therapy, etc.)
- Educational outcomes are not funded through NC. Educational outcomes include those that are the responsibility of the school under IDEA, including responsibilities for children who are placed in private or home schools, or those activities related to completion of homework that are the responsibility of the parent.
- See Appendix M for information on Limits on Sets of Services, including Limits as related to partial school weeks. The Limits on Sets of Services for Children:
 - o Applies to participants enrolled in school and/or those participants under 18 years of age
 - o School days are defined as any day that the school is in session for all or part of that school day
 - o When a school is not in session for part of a week, the limits on sets of services are prorated to accommodate the school being closed for part of the week
- A modified school day equals a full school day for the purposes of the Limits on Sets of Services

General Information on Use of Equipment and Supply Services

Equipment and Supply definitions in the NC Innovations Waiver are: Assistive Technology; Equipment and Supplies; Community Transition Supports; Home Modifications; and Vehicle Adaptations. The following information applies to the use of NC Innovations Equipment Service Definitions.

- Equipment purchased with NC Innovations funds belongs to the participant and the transfer of the equipment to the participant is on the inventory of the Agency providing the equipment. This includes the PIHP and the Community Guide Agency
- Equipment is not covered if it is to be used for the convenience of care providers. This includes duplicate equipment requests because the

participant resides or visits in two households. Purchases of multiple types of equipment for the purpose implementing the same or similar outcomes may not be approved unless the ISP and evaluations clearly indicate the medical necessity of the use of the multiple items. Usually one type of equipment is approved for the same outcome.

- If the requested NC Innovations equipment and supplies requires a physician's order, the order must state that the equipment is "medically necessary". A physician's order in itself does not make an item medically necessary in the context of Medicaid coverage. The order allows the item to be billed if it meets Medicaid criteria. The physician's order may be on the evaluation or may be on a separate document as determined by PIHP policy/procedure.
- The number of quotes required for equipment purchases is determined by PIHP policy/procedure.
- Minor medical and surgical supplies routinely used in the care of the participant are not billed under NC Innovations services.
- Training materials are included as part of the service, and are provided by the provider agency, Agency With Choice or Employer of Record through the Financial Support Services Agency. Personal items are to be purchased by the waiver participant from personal funds.
- Medical equipment may be purchased prior to an individual's discharge from the institutional setting (ICF-MR facility) under the following conditions:
 - i. Waiver services covered are Assistive Technology: Equipment and Supplies; Community Transition Services; Home Modifications; and Vehicle Adaptations.
 - ii. The equipment is obtained no sooner than 60 days prior to the scheduled date of transition to a community living arrangement.
 - iii. The claim is not made until after the individual is discharged from the ICF-MR setting and admitted to the NC Innovations Waiver.

Location of Services

Services generally can be provided at a location that best meets the participant's needs. However some services must be provided at a specific location. Refer to the service definition for specific information about any limitations on when a service can be provided.

The following information applies to waiver participants living in facilities or those who are considering moving to facilities:

- Individuals who are **new** participants to the waiver effective April 1, 2010 must live in private homes or facilities with six beds or less.
- A new participant is a person who was not enrolled in the NC Innovations waiver as of April 1, 2008. Participants transitioning with their respective LME/PIHP from CAP-MR/DD to NC Innovations are not considered new participants for the purposes of waiver eligibility.
- Participants in the NC Innovations Waiver or individuals transitioning to NC Innovations may live in private homes or in the following types of facilities:

Supervised Living Type B for Children with DD; Type C for Adults with DD:

- Supervised Living facilities may not exceed 6 beds except that any facility licensed on June 15, 2001, for more than 6 beds at that time are grandfathered in at no more than the facility's capacity.
- To participate in the waiver, these facilities must meet home and community characteristics
- Any facility greater than six licensed beds will have no new admissions of waiver participants
- Newly developed facilities may participate only if they are licensed for 3 beds or less

Supervised Living Type F for Children or Adults with DD (Alternative Family Living)

- Cannot exceed 3 beds
- To participate in the waiver, these facilities must meet home and community characteristics

Family Care Homes

- Cannot exceed 6 beds
- To participate in the waiver, these facilities must meet home and community characteristics
- Newly developed facilities may participate only if they are licensed for 3 beds or less

Home and Community Characteristics for All Facilities

***** 6/22/12 – This Section is subject to change based on CMS Guidance and will be updated as needed.**

The following home and community living standards must be met by all facilities. They must be applied to all residents in the facility except where such activities or abilities are contraindicated specifically in a participant's person centered plan and applicable due process has been executed to restrict any of the standards or rights. Residents must be respectful to others in their community and the facility has the authority to restrict activities when those activities are disruptive or in violation of the rights of others living in the community.

- Telephone Access
 - Must be available 24/7/365
 - Operator Assistance must be available if necessary
 - Must be private
 - Residents are permitted to have and maintain personal phones in their rooms
- Visitors
 - Must be allowed at any time 24/7/365
 - Does not require facility approval (although facility may require visitors to sign in or notify the facility administrator that they are in the facility)
 - Must not have conduct requirements beyond respectful behavior toward other residents

- Living Space
 - Must have no more than 2 residents to a room
 - If two individuals must share a room, they will have choice as to who their roommate is; under no circumstances will individuals be required to room together if either of them objects to sharing a room with the other
 - Must have the ability to work with the facility to achieve the closest optimal roommate situations
 - Must have the ability to lock the rooms
 - Must be allowed to decorate and keep personal items in the rooms
 - Residents must be able to come and go at any hour
 - Residents must have an individual personal lockable storage space available at any time
 - Must be able to file anonymous complaints
 - Residents must be permitted to have personal appliances and devices in their rooms
- Service Customization
 - Residents must be given maximum privacy in the delivery of their services
 - Residents must be provided choice(s) in the structure of their Service delivery (services and supports, and from where and whom)
 - Include the individual in care planning process as well as people chosen by the individual to attend care plan meetings
 - Provide the appropriate support(s) to ensure the individual has an active role in directing the process
 - Person centered planning process must be at convenient locations and times for individuals to attend
 - Ensure there are opportunities for the person centered plan are updated on a continuous basis
- Kitchen
 - Must be accessible 24/7/365
 - Must have accessible appliances
 - Residents must have input on food options provided
 - Residents must be allowed to choose who to eat meals with including the ability to eat alone if desired
- Group Activities
 - Residents must be given the choice of participating in the facility's recreational activities
 - Residents must be allowed to choose who to participate in recreational activities with
- Community Activities
 - Residents must be given the ability to take part in community activities of their choosing
 - Residents must be encouraged to remain active in their community

- Residents must not be restricted from participating in community activities of their choosing
- Community Integration
 - Would anyone view this residence as part of the community?
 - How could the facility correct the above to become more integrated into the community?

Monitoring for Home and Community Character

***** 6/22/12 – This Section is subject to change based on CMS Guidance and will be updated as needed.**

The State will require the PIHP's to conduct a review of each facility with four or more beds (# of beds specified in the 1915 (c) Technical Guide) in which waiver participants live. The review will be annually for compliance with home and community requirements with active in-reach activities to provide consumer education and choice regarding other housing options. A State-approved standardized review tool will be used and reviews will be conducted and reported to the State on a quarterly basis. Findings of non-compliance will result in immediate suspension of the facility's license participation in NC Innovations. The facility will be given 30 days to come into compliance. At the end of the 30 days, an on-site visit will be made by the PIHP and if the facility is fully compliant, the suspension will be lifted. If not, the facility will be terminated from NC Innovations and waiver participants residing in the facility will be required to move in order to continue participating in the waiver.

Services in the Home of a Direct Service Employee

If a participant needs to receive Personal Care or Respite services in the home of a direct service employee, the Provider Agency, Employer of Record or Agency with Choice is required to complete the Health and Safety Checklist/Justification for Services provided in a Direct Service Employee's home prior to the delivery of service in that home. For the purposes of transition between CAP-MR/DD and NC Innovations, the PIHP may complete the checklist within 90 days of the date the PIHP transitions to NC Innovations for sites that the individual has been receiving CAP-MR/DD waiver services. The participant or legally responsible person will be asked to sign this checklist. Participants should consider the provision of services in the direct service employee's home very carefully. While the checklist covers basic health and safety concerns, it does not provide for an independent review or cover the same areas that formal licensure of service locations covers. See Appendix Q for the Checklist.

Services Provided Outside North Carolina

In accordance with 42 CFR 431.62, waiver services to be delivered out of state are subject to the same requirements as services delivered out of state under the State Medicaid Plan. For participants living in counties bordering another state, the participant may receive services from an enrolled NC Innovations Provider Agency who is within 40 miles of the border of the county.

These guidelines are to be used when families/participants are traveling out of state:

- Services are for participants who have been receiving services from direct care staff while in state and who are unable travel without their assistance
- Participants who live in alternative family living homes or foster homes may receive services when traveling with their alternative family living or foster family out of state under these guidelines
- Participants who are residing in residential settings are allowed to go out of state on vacation with their residential provider and continue to receive services as long as the participant's cost of care does not increase.
- Written prior approval of this request for their staff to accompany families/ participants out of state must be received from the supervisor of the staff person and the PIHP. See Appendix J for the form that is submitted to the PIHP.
- Waiver services may not be provided outside of the United States of America.
- Provider Agencies must ensure that the staffing needs of all their participants can be met.
- Supervision of the direct service employee and monitoring of care must continue.
- The ISP must not be changed to increase services while out of state. Services can only be reimbursed to the extent they would be had they been provided in state, and only for the benefit of the participant.
- Respite services **are not** provided during out of state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive other state's licensure laws. A NC licensed professional may or may not be licensed to practice in another state.
- Medicaid funds cannot be used to pay for room, board, or transportation costs of the participant, family, or staff.
- Provider agencies, Employers of Record and Agencies With Choice assume all liability for their staff when out of state.

Provision of North Carolina Innovations Waiver Service by a Participant's Family Member

The biological or adoptive parent of a minor child, step-parents of a minor child, or spouse of a waiver participant **may not be paid** to provide waiver services to a waiver participant. Other relatives, including legal guardians, may be hired to provide waiver services subject to specifications in the service definition. Relatives and legal guardians of children who are not the biological or adoptive parent of the minor child, step-parents of a minor child may provide services subject to specifications in the service definition.

The following policy applies to legal guardians, parents of adult participants and other relatives **who live in the home of the participant**:

- The waiver services that relatives or legal guardians may provide are Community Networking, Day Supports, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services and Residential Supports.
- The relative or legal guardian must meet the provider qualifications for the service.
- A qualified provider who is not a relative or legal guardian is (a) not available to provide the service or (b) is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member or legal guardian.

- The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.
- The Employer of Record or Managing Employer in an Agency with Choice model may not furnish a service that is subject to the Employer of Record or Managing Employer's direction.
- Ordinarily, no more than 40 hours of service per week or seven daily units per week may be approved for service provision between all relatives who reside in the same household as the waiver participant. Additional service hours furnished by a relative or legal guardian who resides in the same household as the waiver participant may be authorized to the extent that another provider is not available or is necessary to assure the participant's health and welfare.
- When a relative or legal guardian is the service provider, provider agencies, and/or the Managing Employers, as appropriate, monitor the relative or legal guardian's provision of services on-site, at a minimum of one time per month.
- When a relative or legal guardian is the service provider, the Care Coordinator monitors the relative's provision of services on-site at a minimum of one time per month.
- Payments are only made for service authorized by the PIHP in the Individual Support Plan.
- For NC innovations Waiver services, the same monitoring procedures apply to parents and legal guardians as apply to provider agencies to ensure that payments are made only for services rendered.
- The use of a neutral advocate is required for all relatives who are legal guardians to ensure that the desires and needs of the waiver participant are addressed by the ISP planning team.

Provider Agencies, Employers of Record and Managing Employers (through the Agency with Choice) submit documentation to the PIHP that demonstrate that the relative or legal guardian meets the qualifications to provide the service along with the justification for using the relative or legal guardian as the service provider rather than an unrelated provider. The request must be approved prior to service provision by the relative or legal guardian. The forms used to make this request are located in Appendix P. Requests that are not approved may be grieved by the Provider Agency, Employer of Record or Managing Employer through the Agency with Choice. Participants or family members/guardians dissatisfied with the decision may file a complaint.

Provider Qualifications and Verification of Provider Qualifications

Agencies providing NC Innovations Services must meet all rules, governing the licensing and operation of such agencies as specified by the Department of Health and Human Services (DHHS), the Division of Health Service Regulation (DHSR), the Division of Medical Assistance (DMA), and Division of Mental Health, Developmental Disabilities and Substance Abuse (DMH/DD/SAS) Services, as applicable. Agencies that provide NC Innovations Services must have a contract with the PIHP for the service or services that the agency provides.

Provider requirements for each service are specified following each service definition. Both requirements for direct service employees employed by provider agencies, Employers of Record and Agencies With Choice are specified as applicable for each

service definition. Waiver service providers shall not have been excluded or suspended from participation in the Medicare or Medicaid Programs.

Provider Qualifications are verified as follows:

- Facilities, alternative family living homes, adult day health and day care programs, developmental day care programs, before and after school programs operated by the NC Public School System, provider agencies, provider agencies operating private respite homes, nursing respite provider agencies, home care agencies providing nursing respite, Employers of Record and Agencies With Choice verify employee qualifications at the time employees are hired.
- The PIHP reviews facilities, alternative family living homes, adult day health and day care programs, developmental day care programs, before and after school programs operated by the NC Public School System, provider agencies, provider agencies operating private respite homes, nursing respite provider agencies, home care agencies providing nursing respite, and Agencies With Choice when they are initially approved to enter the PIHP Provider Network. The PIHP re-verifies agency credentials, including a sample of employee qualifications, no less than every three years. Employee qualifications are also reviewed during annual reviews of Employers of Record.
- The qualifications of Vendors, Alert Response Centers, Durable Medical Equipment Providers, Home Care Agencies, and Commercial Retail Businesses are verified by the PIHP, Agencies With Choice, or Community Guide Agencies prior to first use.
- The qualifications of Independent Practitioners are verified when they enter the PIHP Provider Network and annually thereafter.

Service definitions and qualifications are listed on the following pages.

Service Definitions

The following definitions and the specific provider requirements for each definition are included in the following pages of this Chapter.

Assistive Technology Equipment and Supplies: T2029

Assistive Technology Equipment and Supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of participants. This service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the participant, 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 participant. A physician's signature certifying medical necessity shall be included with the written request for Assistive Technology Equipment and Supplies.

Assistive Technology: Equipment and Supplies covers the following:

I. Aids For Daily Living

1. Adaptive equipment to enable a participant to feed him/herself (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper, trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, and glasses that are specifically designed to allow a participant to feed him/herself)
2. Adaptive hygiene and dressing aids
3. Adaptive switches and attachments
4. Adaptive toileting and bath chairs
5. Adaptive toothbrushes
6. Assistive devices for participants with hearing and vision loss (e.g. assistive listening devices; TDD, large visual display devices, Braille screen communicators, FM Systems, volume control large print telephones, and teletouch systems)
7. Food/fluid thickeners for dysphasia treatment
8. Positioning chairs, and beds
9. Non-disposable clothing protectors
10. Non-disposable incontinence items with disposable liners for use by participants ages three and above
11. Nutritional Supplements for adults recommended by a physician that are taken by mouth rather than by tube and which are not covered by Medicaid State plan as a Home Infusion Therapy benefit. These are included in the Individual Support Plan and Individual Budget are billed by the PIHP.
12. Special Clothing to meet the unique needs of the participant with a disability
13. Toilet trainer with anterior and lateral supports
14. Universal holder accessories for dressing, grooming and hygiene

II. Gross Motor Development

- (1) Adaptive Tricycles for gross motor development

III. Environmental Control

1. Specialized Global Positioning (GPS) Devices when recommended by a licensed psychologist or licensed psychological associate and accompanied by a behavior support plan that describes how paid or natural supports will supervise the participant who is using the recommended device.
2. Computer equipment, adaptive peripherals and adaptive workstation to accommodate access from bed to power mobility device when it allows the participant control of his or her environment, reduces paid supports, assists in gaining independence, or when it can be demonstrated that it is necessary to protect the health and safety of the participant.
3. Software is approved only when required to operate accessories included for environmental control or to support the participant in planning and budgeting.

Computers will not be authorized to improve socialization or educational skills, provide recreation or divisional activities, or to be used by any other person other than the participant.

IV. Positioning Systems

1. Stenders with trays and attachments for adults
2. Prone boards with attachments for adults
3. Positioning chairs and sitters for participants who do not use a wheelchair for mobility
4. Therapeutic balls
5. Therapy mats when used with adaptive positioning devices
6. Car seats that are necessary for positioning children who require specialized seating while being transported

V. Alert Systems

Alert systems are limited to participants **who live alone or who are alone for significant parts of the day**, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. This service may also be used by participants who live in private homes if the use of the equipment results in a fading or reduction of paid services or prevents the need for additional paid services. Equipment purchase and monthly monitoring charges are covered for the following:

1. Personal Emergency Response Systems (PERS)
2. Alarm systems/alert systems, including auditory, vibratory, heat sensing and visual to ensure the health and safety of the participant, as well as signaling devices for participants with hearing and visual loss
3. Telephone Line Restoration Systems when participant fails to hang the phone up during suspected health and safety issues
4. In Activity Motion Detectors
5. Lockboxes to enable emergency responders to enter the participant's home without damage to windows or doors

6. Medical alarms that offer live two-way voice communication without handheld devices (such as telephones), including remotely located speakers and microphones.
7. Medical alarms that connect participants directly to family members or friends who are willing and able to respond to emergency requests from the participant. The participant's Individual Support Plan identifies the natural support systems who have agreed to respond to emergency requests from the participant.
8. Medication Reminder Systems and/or Monitored Automatic Pill Dispensers
9. Pre-paid, pre-programmed, cellular phones that allow a participant who is participating in employment or community activities without paid or natural supports and who may need assistance due to an accident, injury, or inability to find the way home. The participant's Individual Support Plan outlines a protocol that is followed if the participant has an urgent need to request help while in the community. Cellular phones are not for convenience or general purpose use and costs associated with non-emergency use are excluded.
10. Supervised Photoelectric Smoke Detectors

VI Repair of Equipment

1. Repair of Equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant must own any equipment that is repaired.
2. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Exclusions	1. Items that are not of direct or remedial benefit to the participant are excluded from this service. 2. Computer desks and other furniture items are not covered. 3. Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.
Limits on amount, frequency, or duration	The service is limited to expenditures of \$15,000 over the duration of the waiver. This limit does not include nutritional supplements and monthly alert monitoring system charges.
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed

Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements and regulations for type of device that the business is providing
Alert Response Centers	Applicable state/local business license		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
Durable Medical Equipment Providers	Applicable state/local business license	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the business is providing
Home Care Agencies	Licensed by the NC DHHS, Division of Health Services Regulation, in accordance with NCGS 131E, Article 6, Part C	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the business is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements and regulations for type of device that the business is providing

Community Guide: Periodic-T2041 U1; Monthly-T2041
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Community Guide Services provide support to participants and planning teams that assist participants in developing social networks and connections within local communities. The purpose of this service is to promote self-determination, increase independence and enhance the participant's ability to interact with and contribute to his or her local community. Community Guide Services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the participant's needs in addition to paid services.

These services also support participants, representatives, and Managing Employers who direct their own waiver services by providing direct assistance in their participant direction responsibilities. Community Guide Services are intermittent and fade as community connections develop and skills increase in participant direction. Community Guides assist and support (rather than direct and manage) the participant throughout the service delivery process. Community Guide Services are intended to enhance, not replace, existing natural and community resources.

Specific functions are:

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| <ol style="list-style-type: none"> 1. Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the participant meaningful community integration and inclusion 2. Support to develop social networks with community organizations to increase the participant's opportunity to expand valued social relationships and build connections within the participant's local community 3. Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving Individual Support Plan (ISP) outcomes: this includes social and educational resources, as well as natural supports 4. Instruction and counseling which guides the participant in problem solving and decision making 5. Advocacy and collaborating with other individuals and organizations on behalf of the participant 6. Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plan) 7. Providing training on the Individual and Family Directed Supports Option, if the participant is considering directing services and supports (Agency With Choice and Employer of Record Models) 8. Guidance with management of the Individual & Family directed budget (Agency With Choice and Employer of Record Model) 9. Coordinating services with the Financial Support Services provider, if the individual is self-directing services under the Employer of Record Model, including guidance on use of the Individual and Family Directed (Participant-Directed Budget) (Employer of Record Model) 10. Providing information on recruiting, hiring, managing, training, evaluating, and changing support staff, if the participant is self-directing services (Agency With Choice and Employer of Record Models) 11. Assisting with the development of schedules and outlining staff duties, if the participant is self-directing services considering directing services and supports (Agency With Choice and Employer of Record Models) 12. Assisting with understanding staff financial forms, qualifications and record keeping requirements, if the participant is self-directing services (Agency With |
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Choice and Employer of Record Models) 13. Providing on-going information to assure that participants and their families/representatives understand the responsibilities involved with participant direction, including reporting on expenditures and other relevant information and training (Agency With Choice and Employer of Record Models) 14. Coordinating services with the Agency with Choice if the participant is directing services under the Agency with Choice Model 15. Informing and coordinating community resources including coordination among primary, preventative and chronic care providers 16. Assistance in locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence			
Exclusions	1. This service does not duplicate care coordination. Care coordination under managed care includes assisting the participant in 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 participant consistent with 42 CFR 438.208(c). 2. The provider of Community Guide Services that does not provide Agency With Choice Services may only additionally provide Community Transition. 3. The Community Guide Services Provider may provide Agency With Choice Services to the same individual. If the Community Guide Services Provider is providing Agency With Choice Services to a participant, the Provider may additionally provide Community Transition, Financial Support Services, Individual Goods and Services, and Primary Crisis Response Services to the individual. 4. Community Guide Services are only to be used to provide support for Participant Direction activities as approved in this waiver, Individual and Family Directed Supports: Employer of Record and Agency With Choice Models.		
Limits on amount, frequency, or duration			
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-			NC G.S. 122C as applicable

directed arrangement			Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice At least 18 years old If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background checks present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of participant as described in the ISP High school diploma or equivalency (GED) 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. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012
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			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 the requirements of the PIHP. Meets Community Guide Competencies as specified by DMA. See Appendix T
Provider Agencies		NC G.S. 122C, as applicable	Approved as a provider in the PIHP provider network: Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background checks present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 as specified by DMA. See Appendix T.
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**Community Networking: Service-H2015; Class and Conference-H2015U1;
Transportation- H2015U2**

Community Networking services provide individualized day activities that support the participant's definition of a meaningful day in an integrated community setting, with persons who are not disabled. This service is provided separate and apart from the participant'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 participant 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 participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As participants gain skills and increase community connections, service hours should fade; however a formal fading plan is not required.

Community Networking services consist of:

1. Participation in adult education;
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 participant to make community connections; and/or
9. For children, this service includes staffing supports to assist children to participate in day care/after school summer programs that serve typically developing children and are not funded by Day Supports.
10. Transportation when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage.

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

Payment for attendance at classes and conferences is also 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 participant's home/residential life or services.

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

activities. The service may not duplicate services provided under Community Guide, Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, and/or Supported Employment services. This service may not be furnished/claimed at the same time of day as Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the participant. For participants who are eligible for educational services under the Individuals With Disability Educational Act, Community Networking does not include transportation to/from school settings. This includes transportation to/from participant's home or any community location where the participant may be receiving services before/after school. This service does not pay for overnight programs of any kind. Memberships of any type are not covered under this definition. Classes that offer one-to-one instruction and are in a nonintegrated community setting are not covered.			
Limits on amount, frequency, or duration		Payment for attendance at classes and conferences will not exceed \$1000/ per participant plan year. The amount of community networking services is subject to the "Limits on Sets of Services" specified in Appendix M. The amount of community networking services is subject to the amount of the participant's Support Need Matrix Category Budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix.	
Service Delivery Method		■ Provider Directed ■ Individual/Family Directed	
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement			NC G.S.122C as applicable Approved by employer of record or recommended by Managing Employer and approved by Agency with Choice Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of

			automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP High school diploma or equivalency (GED) Supervised by the Employer of Record and the 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. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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
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			Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
Provider Agencies			Approved as a provider in the PIHP provider network: Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background checks present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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.
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Community Transition: T2038			
Community Transition is one-time, set-up expenses for adult participants to facilitate their transition from a Developmental Center (institution), community ICF-MR Group Home, nursing facility or another licensed living arrangement (group home, foster home, or alternative family living arrangement) to a living arrangement where the participant 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 participant's/legal guardian's/representative's name or a home owned by the participant. <u>Covered transition services are:</u> 1. Security deposits that are required to obtain a lease on an apartment or home; 2. Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens; 3. Moving expenses required to occupy and use a community domicile; 4. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and/or 5. Service necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy. Community Transition expenses are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. These supports may be provided only once to a waiver participant. These services are available only during the three-month period that commences one month in advance of the participant'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. See Appendix U for the Checklist.			
Exclusions	Community Transition does not include monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, 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.		
Limits on amount, frequency, or duration	The cost of Community Transition has a life time limit of \$5000.00 per participant. Community Transition includes the actual cost of services and does not include provider overhead charges.		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Specialized Vendor Suppliers			Meets applicable state and local regulations for type of service that the provider/supplier is

			providing as approved by PIHP
Agencies that provide Community Guide Services			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
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP

**Crisis Services: Primary Response-H2011; Behavioral Consultation-T2025-U3 ;
Out of Home-T2034**

Crisis Services is a tiered approach to support waiver participants when crisis situations occur that present a threat to the participant's health and safety or the health and safety of others. These behaviors may result in the participant losing his or her home, job, or access to activities and community involvement. Crisis Services is an immediate intervention available 24 hours per day, 7 days per week to support the person who is primarily responsible for the care of the participant. Crisis Services is provided as an alternative to institutional placement or psychiatric hospitalization. Service authorization can be accessed by telephone or planned through the Individual Support Plan (ISP) to meet the needs of the participant. Following service authorization, any needed modifications to the Individual Support Plan and Individual Budget will occur within five working days of the date of verbal service authorization.

Primary Crisis Response

Trained staff is available to provide "first response" crisis services to waiver participants 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 participant during behavioral episodes;
- Contact the Care Coordinator following the intervention to arrange Crisis Behavioral Consultation for the participant; and/or
- Provide direction to service providers who may be supporting the participant in day programming and community settings, including direct intervention to de-escalate behavior or protect others during behavioral episodes (enhanced staffing to provide one additional staff person in settings where the participant may be receiving other services).

Crisis Behavioral Consultation

Crisis Behavioral Consultation is available to participants that have intensive, significant, challenging behaviors that have resulted in a crisis situation requiring the development of a Crisis Support plan.

These activities include:

1. Development or refinement of interventions to address behaviors or issues that precipitated the behavioral crisis and/or
2. Training and technical assistance to the Primary Responder and others who support the participant on crisis interventions and strategies to mitigate issues that resulted in the crisis.

Out of Home Crisis

Out of Home Crisis is a short-term service for a participant 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 a participant cannot be safely supported in the home, due to his or 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 are unable to access regular respite due to the nature of their behaviors. Crisis Services will be authorized in 14 calendar day increments. In situations requiring Crisis Services in excess of 14 calendar days, the PIHP must approve such authorization based on review of a transition plan that details the transition of the participant from crisis supports to other appropriate services.			
Exclusions	This service may not duplicate services provided under Specialized Consultation Services.		
Limits on amount, frequency, or duration	Crisis Services is considered an "Add On" to the Individual Budget and should be used as clinically appropriate for the participant.		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Provider Agencies (Primary Crisis Response Services)			Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR, NCI, and First Aid Qualified in the customized needs of the participant as described in the ISP

			Provided by a qualified professional in the field of developmental disabilities Meets Crisis Services Competencies specified by DMA. See Appendix T. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies. Organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.
Independent Practitioners or Provider Agencies (Crisis Behavioral Consultation)	Licensure specific to discipline as		Approved by the PIHP as an Independent Practitioner or as a provider in the PIHP provider network Staff that work with participants: Are at least 18 years old Criminal background check presents no health and safety risk to participant 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 DMA. See Appendix T. Qualified in 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 accreditation agencies. If a provider agency the organization must be established as a legally constituted entity, capable of meeting

			all the requirements of the PIHP
Provider Agencies who operate licensed facilities	NC G.S, 122C 10 NCAC 27G.5100 or waiver licensure granted by licensing agency		Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP Meets Crisis Services Competencies specified by DMA. (See Appendix T.) High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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.
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Day Supports Individual-T2021; Group-T202HQ; Developmental Day-T2027	
Day Supports is primarily a group service that provides assistance to the participant with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day Supports are furnished in a non-residential setting, separate from the home or facility where the participant resides. Day Supports focus on enabling the participant to attain or maintain his or her maximum functional level and is coordinated with any physical, occupational, or speech therapies listed in the Individual Support Plan. Transportation to/from the participant's home, the day supports facility and travel within the community is included. The cost of transportation to and from the day program is included in the payment rate. Day Supports may include prevocational activities. The following criteria differentiate between prevocational and vocational services. 1. Prevocational services are provided to persons who are not expected to join the general work force or participate in transitional sheltered workshops within one year of service initiation 2. If compensated, the participant may on average, receive less than 50 percent of minimum wage. 3. Services include activities that are not directed at teaching job-specific skills but at underlying habilitative goals (e.g. attention span, motor skills, attendance, and task completion.) Day Supports may not be used for the provision of vocational services (e.g. sheltered workshop preformed in a facility). Vocational services which assist participants in learning to perform real jobs are to be provided in community settings and not in licensed facilities. Prevocational skills development where participants obtain the underlying habilitation skills required for obtaining a job may be provided in the licensed day support setting. For participants who do not receive Residential Supports, transportation to and from the home of the participant is built into the rate for Day Supports. Time once the participant reaches the licensed day program can be billed to Day Supports. Transportation to and from the licensed day program is the responsibility of the Day Supports provider. If the participant leaves the facility to participate in community programming, the Day Supports authorization includes the time the participant is transported to and from community activities. Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the Individual Support Plan and the service originates from the licensed day program. All licensure categories must be followed and the participant grouping must be appropriate to the age of the participant. For participants who are eligible for educational services under the Individual's With Disability Educational Act. Day Supports does not include transportation to/from school settings. This includes transportation to/from the participant's home or any community location where the participant may be receiving services before or after school.	
Exclusions	This service may not duplicate services provided under Community Networking, In-Home Intensive Supports, In-Home Skill Building, Residential Supports, Supported Employment and/or one of the State Plan Medicaid Services that works directly with the participant. This service shall not be furnished/billed at the same time of day as Community

	Networking, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Residential Supports, Respite, Supported Employment and/or one of the State Plan Medicaid services that works directly with the person.		
Limits on amount, frequency, or duration	The amount of Day Supports is subject to the Limits on Sets of services specified in Appendix M. The amount of Day Supports Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Provider Agencies	NC G.S. 122 C	NC G.S. 122 C	Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP. High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. 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
Adult Day Health and Day Care Programs		Certified by NC Division of Aging	Approved as a provider in the PIHP provider network Agency staff that work with participants: Criminal background check present no health and safety risk to participant 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 Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP. High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012
Licensed Developmental Day Care Programs	NC G.S. 122 C	NC G.S. 122 C	Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old

			If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to participant Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. 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
Before and			Approved as a provider in the PIHP

After School Day Care Programs Operated by NC Public School System			provider network Agency staff that work with participants: Criminal background check present no health and safety risk to participant 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 Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP. High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. 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.
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Financial Support Services-T2025-U1 Employer Supplies T2025U2			
Financial Support Services is the umbrella service for the continuum of supports offered to NC Innovations individuals who elect the Individual and Family Directed Services Option, Employer of Record Model. Financial Support Services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the Employer. (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 individual's funds; (7) Producing expenditure reports that are required, including reports to the individual/ 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.			
Exclusions	The provider of Financial Support Services may only additionally provide Community Guide Services, Community Transition Services, and Individual Goods and Services under the NC Innovations waiver. The Financial Support agency may provide Agency With Choice, community transition and individual goods and services as well as community guide services to the same individual.		
Limits on amount, frequency, or duration	Financial Support Services is considered an "Add On" to the Individual Budget. This service is required of all individuals who elect the Employer of Record Model in the Individual/Family Directed Supports Option.		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Provider Agencies	Applicable state/local business license		NC G.S. 122C, as applicable Approved as a provider in the PIHP provider network Approved by the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6, 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
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Home Modifications: S5165

Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned by the participant or his/her family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant. A physician's signature certifying medical necessity shall be included with the written request for Home Modifications.

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

Covered Modifications are:

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 a participant's home
5. Porch stair lifts
6. Modifications and/or additions to bathroom facilities
 - a. Roll in shower
 - b. Sink modifications
 - c. Bathtub modifications/grab bars
 - d. Toilet modifications
 - e. Water faucet controls
 - f. Floor urinal and bidet adaptations
 - g. Plumbing modifications
7. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
8. Specialized accessibility/safety adaptations/additions
 - a. Electrical wiring
 - b. Fire/safety adaptations
 - c. Shatterproof windows
 - d. Floor coverings for ease of ambulation
 - e. Modifications to meet egress regulations
 - f. Automatic door openers/doorbells
 - g. Voice activated, light activated, motor activated electronic devices to control the participants home environment
 - h. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
 - i. Stationary built in therapeutic tables
 - j. Voice activated, light activated, motor activated electronic devices to control

the participant's home environment k. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant l. Stationary built in therapeutic tables.			
Exclusions		Modification Lists are exhaustive. 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). Participants who receive Residential Supports may not receive this service. Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered. 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 (financing of a new home, down payment of a new home, etc.) Items that would normally be available to any child, and are ordinarily provided by the family, are not covered.	
Limits on amount, frequency, or duration		The service is limited to expenditures of \$20,000 over the duration of the waiver.	
Service Delivery Method		☒ Provider Directed ☐ Individual/Family Directed	
Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		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.
Commercial/Retail Businesses	Applicable state/local business license		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.

In-Home Intensive Supports T1015			
In- Home Intensive support is available to support participants in their private home, when the participant needs extensive support and supervision. Habilitation, support and/or supervision are provided to assist with positioning, intensive medical needs, elopement and/or behaviors that would result in injury to self or other people. Staff implements interventions and assistance as defined in the ISP. The ISP includes an assessment and a fading plan or plan for obtaining assistive technology to reduce the amount of intensive support needed by the participant. Authorization Process: 1. In-Home Intensive Supports may only be provided to participants who have exceptional medical or behavioral support needs on the Supports Intensity Scale assessment. Until the participant has a Supports Intensity Scale assessment, the NC SNAP is used and the participant must have a score of at least 4 or 5 in Medical and/or Behavioral. 2. In-Home Intensive Support requires prior authorization by PIHP 3. In-Home Intensive Support requires approval by PIHP at a minimum of every 90 days. These services are provided in the participant's private home, not in the home of the direct service employee. Participant may receive personal care or community networking outside the private home. These services are not provided in the home or office of a staff person or agency.			
Exclusions	This service is not provided to participants who receive Residential Supports. This service may not be furnished / billed at the same time of day as Day Supports, Community Networking, In-Home Skill Building, Personal Care, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person. For participants who are eligible for educational services under the Individual's With Disability Educational Act, In-home intensive support does not include transportation to/from school settings. This includes transportation to/from the participant's home, provider home where the participant is receiving services before/after school or any community location where the participant may be receiving services before or after school.		
Limits on amount, frequency, or duration	The amount of In Home Intensive Supports is subject to the Limits on Sets of Services specified in Appendix M. The amount of In Home Intensive Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix		
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-			Staff that work with participant are approved by employer of record or recommended by

directed arrangement			the Managing Employer and approved by Agency with Choice Staff are at least 18 years old Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP If providing transportation, have a valid NC driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry High school diploma or equivalency (GED) 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. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 Employers of Record have an arrangement with an enrolled crisis services provider to respond to participant crisis situations Agency with Choice provides or maintains an agreement with a Crisis Service Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider.
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			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 participant as directed by the PIHP Medical Director or Assistant Medical Director Upon or 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 PIHP.
Provider Agencies			Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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.

			Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies. The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.
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In-Home Skill Building Individual-T2013; Group-T2013HQ	
In-Home Skill Building provides habilitation and skill building to enable the participant to acquire and maintain skills, which support more independence. In-Home Skill Building augments the family and natural supports of the participant and consists of an array of services that are required to maintain and assist the participant to live in community settings. In-Home Skill Building consists of 1. Training in interpersonal skills and development and maintenance of personal relationships 2. Skill building to support the participant in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities 3. Training with therapeutic exercises, supervision of self-administration of medication and other services essential to healthcare at home, including transferring, ambulation and use of special mobility devices 4. Transportation to support implementation of in-home skill building In-Home Skill Building is provided when a primary caregiver is home or when that primary caregiver is regularly scheduled to be absent. In-Home Skill Building is individualized, specific, and consistent with the participant's assessed disability specific needs and is not provided in excess of those needs. In-Home Skill Building is furnished in a manner not primarily intended for the convenience of the participant, primary caregiver, the provider, employer of record or the managing employer. This service is distinctive from personal care by the presence of training. The mixture of in-home skill building and personal care must be specified in the Individual Support Plan. It is anticipated that the presence of In-Home Skill Building will result in a gradual reduction in hours as the participant is trained to take on additional tasks and masters skills (fading plan). A formal fading plan is not required. These services are provided in the participant's private home and not in the home of the direct service employee. In-Home Skill Building Services must start and/or end at the home of the participant.	
Exclusions	This service is not provided to participants who receive Residential Supports. This service may not be furnished / billed at the same time of day as Day Supports, Community Networking, In-Home Intensive Supports, Personal Care Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person. For participants who are eligible for educational services under the Individuals With Disability Educational Act, In-Home Skill Building does not include transportation to/from school settings. This includes transportation to/from the participant's home or any other community location where the participant may be receiving services before or after school.
Limits on amount,	The amount of In Home Skill Building is subject to the Limits on Sets of Services specified in Appendix M. The amount of In Home Skill Building also is subject

frequency, or duration	to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.		
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement			Staff that work with participant are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice Staff are at least 18 years of age If providing transportation, have a valid NC driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or equivalency (GED) 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. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 participant as directed by the PIHP Medical Director or Assistant Medical Director Employers of Record have 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. Has an arrangement with an enrolled crisis services provider to respond to participant crisis situations Agency with Choice provides or has an arrangement with an enrolled Crisis Service Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider. The Agency With Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
Provider Agencies			Approved as a provider in PIHP provider network Agency staff that work with participants: Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with participants must be

			qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies. Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider. The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.
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Individual Goods and Services: T1999			
Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Support Plan (including improving and maintaining the participant'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 participant's safety in the home environment; AND (4) the participant 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 participants who self-direct at least one of their services.		
Limits on amount, frequency, or duration	The cost of individual directed goods and services for each participant cannot exceed \$2,000.00 per participant plan year annually.		
Service Delivery Method	☐ Provider Directed ☒ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement			Staff that work with participants are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice 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 present no health and safety risk to participant Are at least 18 years old Not listed in the North Carolina

			Health Care Abuse Registry High school diploma or equivalency (GED) Supervised by the employer of record or managing employer Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP 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. Associate professional providing supervision to paraprofessionals on the date of the of this waiver amendment are grandfathered through 3/31/2012 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 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
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			meeting all of the requirements of the PIHP
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of item that the vendor is providing
Agency With Choice			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
Financial Support-Agency			Agency enrolled with PIHP NC G.S.122C, as applicable Meets applicable state and local requirements for type of item that the vendor is providing

Natural Supports Education: Individual-S5110; Conference-S5111			
Natural Supports Education provides training to families and the participant's natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the participant, 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 participant or the natural support network's ability to provide care and support to the participant. In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver. The expected outcome of this training is to develop and support greater access to the community by the participant 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 participant.		
Limits on amount, frequency, or duration	Reimbursement for conference and class attendance will be limited to \$1,000 per year.		
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement			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 participant 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 participant 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 participant 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
Provider Agencies			Approved as a provider in the PIHP provider network Agency staff that work with participants:

			Are at least 18 years old Criminal background check presents no health and safety risk to participant 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 participants as described in the Individual Support Plan Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
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Personal Care Services S5125	
Personal Care Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills gained during habilitation while also providing supervision for independent activities. This service may include preparation of meals, but does not include the cost of the meals themselves. When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the participant, rather than the participant's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices. Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider, staff or an Employer of Record, or staff of an Agency With Choice if there is documentation in the ISP that the participant's needs cannot be met in the participant's private home or another community location.	
Exclusions	Personal Care Services do not include medical transportation and may not be provided during medical transportation and medical appointments. Participants, who live in licensed residential facilities, licensed AFL homes, licensed foster homes, or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service or any other State Plan Personal Care Service. Personal Care cannot be provided in a licensed program. This service may not be provided on the same day that the participant receives State Plan Medicaid Personal Care Services, a home health aide visit, Residential Supports or another substantially equivalent service. This service may not be provided at the same time of day that a participant receives Day Supports, Community Networking, In-Home Intensive Support, In-Home Skill Building, and Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person. The service does not cover the staff member completing home maintenance, housekeeping for areas that are used by other members of the household and/or meal preparation when the same meal is being prepared for other family members. For participants who are eligible for educational services under the Individuals With Disability Educational Act, personal care does not include transportation to/from school settings. This includes transportation to/from the participant's home, provider home where the participant may be receiving services before or

	after school or any other community location where the participant may be receiving services before or after school. Transportation between the participant's home and the provider's home is not billable service time.		
Limits on amount, frequency, or duration	The amount of Personal Care Services is subject to the limits on sets of services specified in Appendix M. The amount of Personal Care Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.		
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement			Staff that work with participant are approved by employer of record or recommended by the Managing Employer and approved by Agency with Choice Staff are at least 18 years of age 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 participant Not listed in NC Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or equivalency (GED) and supervised by the Employer of Record Supervised by the employer of record or managing employer For service directed by the Agency with Choice, 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. Associate

			professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 participant as directed by the PIHP Medical Director or Assistant Medical Director The Agency With Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. 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 participant crisis situations Agency with Choice provides or maintains an agreement with a Crisis Service Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider. Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or Agency With Choice Qualified Professional
Home Health Agency	Licensed by the Division of Health Service Regulation as a Home Care Agency		Approved as a provider in PIHP provider network Agency staff that work with participants: Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of

			automobile liability insurance Criminal background check present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid and the Qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies. The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP. Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the provider agency Qualified Professional.
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Personal Care Service Provider Agency			Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The individual, however, may select any enrolled Crisis Services provider in lieu of this provider. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least 1 of designated accreditation agencies.
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			The organization must be established as a legally constituted entity, capable of meeting all the requirements of PIHP. Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or provider agency Qualified Professional.
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Residential Supports: Level 1 and Level 1 AFL-H2016; Level 2 and Level 2 AFL-T2014; Level 3 and Level 3 AFL-T2020; Level 4 and Level 4 AFL-H2016H1

Residential Supports consist of an integrated array of individually designed training activities, assistance and supervision.

Residential Supports include:

1. Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to reside as independently as possible in the community.
2. Assistance in activities of daily living when the participant is dependent on others to ensure health and safety.
3. Habilitation services that allow the participant to participate in home life or community activities. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source.

Residential Supports are provided to individuals who live in a community residential setting that meets the home and community based characteristics in Appendix C: 2.

- Facility capacity for all newly developed facilities, approved within the PIHP network and that meet the home and community based characteristics is three beds or less.
- Facility capacity for existing facilities approved within the PIHP network and meet the home and community based characteristics, is six beds or less.
- Facilities that meet the home and community based characteristics, and currently serve a waiver participant, larger than six beds which meet HCBS characteristics as defined in this waiver will be allowed to continue to provide Residential Supports until the waiver participant is discharged from the facility.

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

Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues. See Appendix Y for the checklist.

Home and community environment is described in the Location of Services section earlier in this chapter Home and Community Character will be monitored as described in the Location of Services section described earlier in this chapter

Residential Supports daily rates include payments for relief staff that provide support for the participant in the group home or alternative family living home. Relief staff is provided in the participant's residence and is not provided in a different residential setting.

The NC SNAP is used to determine Residential Support Levels as follows:			
Level 1: SNAP Index 24-44 Level 2: SNAP Index 45-79 Level 3: SNAP Index 80-94 Level 4: SNAP Index 95-230			
Exclusions	Transportation to/from a child's school is the responsibility of the school system rather than the Residential Supports Provider. Transportation to/from medical appointments is billed to State Medicaid Plan Transportation rather than Residential Supports. Participants who receive Residential Supports may not receive Home Modifications, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Respite, Vehicle Modifications, or State Plan Personal Care Services. This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person. Payments for Residential Supports do not include payments for room and board, the cost of facility maintenance and upkeep.		
Limits on amount, frequency, or duration	The amount of Residential Supports is subject to the Limits on Sets of Services specified in Appendix M. The amount of Residential Support Services is also subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Supervised Living facilities 3 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	10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147 Type: B		Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry

facility's licensed capacity. Supervised Living facilities 3 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.	10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147 Type: C		Qualified in CPR and First Aid High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. 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. 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.
Supervised living facilities type F serve no more than 3	NC G.S. 122 C10 A NCAC 27G.5600, statutory		Approved as a provider in the PIHP provider network Agency staff that work with

minors or 3 adults with a developmental disability Unlicensed supervised living homes may only serve one adult based on 10A NCAC 27 G.5601 (b) (1) (2)	authority: NC General Statute 143B-147 Type: F NA	participants: Are at least 18 years old Not listed in the North Carolina Health Care Abuse Registry Criminal background check presents no health and safety risk to participant If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012. Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The
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			Participant may select any enrolled Crisis Services provider in lieu of this provider however. Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. Back-up staff must be employees of the agency.
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Respite: Individual-S5150; Group-S5150HQ; Nursing Respite, RN-T1005TD; Nursing Respite, LPN- T1005TE; Facility-S5150US	
Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the participant. 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. Respite may include in and out-of-home services, inclusive of overnight, weekend care, emergency care (family emergency based, not to include out of home crisis) or continuous care up to ten consecutive (10) days. The primary caregiver is the person principally responsible for the care and supervision of the participant and must maintain his/her primary residence at the same address as the participant. This service includes transportation from the participant's residence to points of travel in the community.	
Exclusions	This service may not be used as a daily service in individual support. This service is not available to participants who receive Residential Supports and/or those who live in licensed residential settings or Alternative Family Living Homes. Staff sleep time is not reimbursable. Respite services are only provided for the participant; other family members, such as siblings of the participant, may not receive care from the provider while Respite Care is being provided/billed for the participant. Respite Care is not provided by any participant who resides in the participant's primary place of residence. FFP will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence. For participants 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 participant's home, provider home where the participant is receiving services before/after school or any community location where the participant may be receiving services before or after school. Respite may not be used for participants who are living alone or with a roommate; staff sleep time is not reimbursable. This service is not available at the same time of day as Community Networking, Day Supports, In-Home Intensive Supports, In-Home Skill Building, Personal Care, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
Limits on amount, frequency, or duration	The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-MR Facility. The amount of Respite Services is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix Continuous care may only be provided for up to ten consecutive (10) days

Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement		NC G.S. 122 C, as applicable	Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice At least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Supervised by the employer of record or managing employer Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP Staff that work with participants must have a high school diploma or high school equivalency (GED) For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate

			discipline. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina Agencies with Choice follow State Nursing Board Regulations Upon enrollment with the PIHP, the Agency With Choice 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 the requirements of the PIHP. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the Agency With Choice qualified professional or the Employer of Record
Provider Agencies, facility based and in-home services	NC G.S. 122 C	NC G.S. 122 C	Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years of age Criminal background check presents no health and safety risk to participant

			If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid the Qualified in the customized need of the participants as described in the Individual Support Plan High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 Licensed RN or Licensed LPN in North Carolina Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted
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			entity capable of meeting all of the requirements of the PIHP
Provider Agencies who operate private respite homes	Private home respite services serving individuals outside their private homes are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.	NC G.S. 122 C	Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP High school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 qualified professional
Nursing Respite, Provider Agencies		NC G.S. 122 C	Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old 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 and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry. Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP Staff that work with participants must have a high school diploma or high school equivalency (GED) 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 qualified professional
Nursing Respite Home Care Agencies	Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6, Part C		NC G.S. 122C, as applicable Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old Staff that work with participants must have a high school diploma or high school equivalency (GED) ; Nursing Respite is 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 and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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 qualified professional
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Specialized Consultation Services: T2025	
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 or nutrition) to assist family members, support staff and other natural supports in assisting participants with developmental disabilities who have long term intervention needs. 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, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists defined to be an integral part of the Individual Support Team to participate in team meetings and provide additional intensive consultation and support for participants whose medical and/or behavioral /psychiatric needs are considered to be extreme or complex. The participant may or may not be present during service provision. The professional and support staff are able to bill for their service time concurrently. Activities covered are: 1. Observing the participant to determine needs; 2. Assessing any current interventions for effectiveness; 3. Developing a written intervention plan; 4. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports; 5. Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies; 6. Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes; 7. Training and technical assistance to relevant persons to instruct them on the implementation of the participant's intervention plan; 8. Participating in team meetings; and/or 9. Tele-consultation through use of two-way, real time-interactive audio and video between places of lesser and greater clinical expertise to provide behavioral and psychological care when distance separates the care from the participant.	
Exclusions	Specialized Consultative Services excludes services provided through Natural Supports Education and Crisis Services. This service may not duplicate services provided to family members through natural supports education
Limits on amount, frequency, or duration	Specialized consultation services exclude services provided through natural supports education and crisis services.
Service Delivery	☒ Provider Directed ☐ Individual/Family Directed

Method	
Provider Type	License Certification Other Standard
Independent Practitioners	Licensure specific to discipline, applicable if Certification or registration specific to discipline, applicable if NC G.S.122C, as appropriate Approved by the PIHP At least 18 years old Criminal background check presents no health and 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 Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology 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
Provider Agencies	NC G.S.122C, as appropriate Approved as a provider in the PIHP provider network Agency staff that work with participants: At least 18 years old Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry

			Qualified in the customized needs of the participant as described in the Individual Support Plan Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; state certification for recreational therapy; board certified behavior analyst-MA; master's degree and expertise in augmentative communication; state certification in assistive technology
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Supported Employment Services: Individual-H2025; Group-H2025HQ

Supported Employment Services provide assistance with choosing, acquiring, and maintaining a job for participants ages 16 and older for whom competitive employment has not been achieved and /or has been interrupted or intermittent.

Initial Supported Employment services include:

1. Pre-job training/education and development activities to prepare a person to engage in meaningful work-related activities which may include career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, assistance in learning skills necessary for job retention.
2. Assisting a participant to develop and operate a micro-enterprise. This assistance consists of:
 - a. Aiding the participant to identify potential business opportunities;
 - b. Assistance in the development of a business plan, including potential sources of business financing and other assistance;
 - c. Identification of the supports that are necessary in order for the participant to operate the business.

3. Coaching and employment support activities that enable a participant to complete initial job training or maintain employment such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling.

Long term follow-up supports include:

1. Coaching and employment support activities that enable a participant to maintain employment in a group such as an enclave or mobile crew
2. Ongoing assistance, counseling and guidance for a participant who operates a microenterprise once the business has been launched;
3. Assisting the participant to maintain employment through activities such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling
4. Employer consultation with the objective of identifying work related needs of the participant and proactively engaging in supportive activities to address the problem or need.

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

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

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 participant's supported employment program For participants who are eligible for educational services under the Individuals With Disability Educational Act, personal care does not include transportation to/from school settings. This includes transportation to/from the participant's home, provider home where the participant may be receiving services before or after school or any other community location where the participant may be receiving services before or after school. This service is not available at the same time of day as Community Networking, Day Supports, In-Home Intensive Services, In- Home Skill Building, Personal Care Services Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.		
Limits on amount, frequency, or duration	The amount of Supported Employment Services is subject to the limitation on the number of hours of services specified in Appendix M. The amount of Supported Employment Services is also subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix 8.		
Service Delivery Method	■ Provider Directed ■ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a participant-directed arrangement		NC G.S. 122 C, as applicable	Staff that work with participants are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Are at least 18 years old

			Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in the customized needs of the participant as described in the ISP Staff that work with participants must have a high school diploma or high school equivalency (GED) Persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide supported employment to the same participant Grandfathering applies to staff employed by a provider agency providing authorized Supported Employment or Long Term Vocational Supports at the time the PIHP and participant transition to NC Innovations. 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. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP
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			Medical Director or Assistant Medical Director Agencies with Choice follow State Nursing Board Regulations Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Competencies as specified by the DMA. See Appendix T.
Provider Agencies		NC G.S. 122 C,	Approved as a vendor in the PIHP provider network Agency staff that work with participants: Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry. Qualified in CPR and First Aid Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. Staff that work with participants must have a high school diploma or high school equivalency (GED)

		Persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide supported employment to the same participant) Grandfathering applies to staff employed by a provider agency providing authorized Supported Employment or Long Term Vocational Supports at the time the PIHP and participant transition to NC Innovations. 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. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012 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. Competencies as specified by the DMA. See Appendix T.
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Vehicle Modifications: T2039	
Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, and training in the care and use of these items are included. The waiver participant or his/her family must own or lease 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 or lease. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. 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. A physician's signature certifying medical necessity shall be included with the written request for Vehicle Modifications. 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. <u>Covered Modifications are:</u> 1. Door handle replacements 2. Door modifications 3. Installation of raised roof or related alterations to existing raised roof system to approve head clearance 4. Lifting devices 5. Devices for securing wheelchairs or scooters 6. Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel 7. Handrails and grab bars 8. Seating modifications 9. Lowering of the floor of the vehicle 10. Safety/security modification	
Exclusions	1. Vehicle Modifications are not available to participants who receive Residential Supports or who live in licensed residential facilities. 2. The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered. 3. Items that are not of direct or remedial benefit to the participant are excluded from this service.

Limits on amount, frequency, or duration	The service is limited to expenditures of \$20,000 over the duration of the waiver.		
Service Delivery Method	☒ Provider Directed ☐ Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing

General Documentation Requirements

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

Services must be documented by all Medicaid providers and done so prior to seeking Medicaid payment. There shall be follow-up documentation to reflect attempts to ascertain why a participant is not participating in a service/support in accordance with the established schedule or plan.

Service Note

For Service Note requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9). The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the Records Management and Documentation Manual.

- Crisis Services (including information as indicated in the participant's intervention plan)
- Community Guide
- Individual Directed Goods and Services (required for service component)
- Natural Supports Education
- Specialized Consultative Services

Service Grid

For service grid requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9). A service grid should include all elements 1 through 10, under Required Elements of a Service Grid, Chapter 8 of the Record Management and Documentation Manual. A service grid shall be completed daily or per activity to reflect the service provided and may only be used for the following services:

- Community Networking
- Day Supports (Services provided to children through Developmental Day Services- Typically Developing children, shall meet the requirements through the NC Division of Child Development's Child Care requirements, subchapter 3U-Child Day care Rules).
- In-Home Intensive Supports
- In-Home Skill Building
- Personal Care services
- Residential Supports
- Respite Care
- Supported Employment

Signatures

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the

Records Management and Documentation Manual 45-2 (Chapter 9) for signature requirements.

Frequency of Service Documentation

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry." Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late Entry made on 2/15/12 for 2/14/12." The late entry must include a dated signature.

Service notes shall be made at the frequency necessary to indicate significant changes in the participant's status, needs or changes in the Individual Support Plan.

Corrections in the Service Record

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

However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

Short-Range Goals, Task Analysis/Strategies

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

- Develop and implement short-range goals
- Develop and implement task analysis/strategies
- Ensure short-range goals and task analysis or strategies are in place prior to plan implementation
- Ensure short-range goals and task analysis or strategies are signed by the participant or Legally Responsible Person.

Progress Summary

Service providers, Agencies With Choice, and Employers of Record are required to complete progress summaries for habilitative services to reflect the participant's progress toward the short-range goal and long-range outcomes that have been implemented in the Individual Support Plan for any of the following Innovation services: Community Networking; Day Supports, In-Home Skill Building, Intensive In Home Supports, Personal Care, Residential Supports and Supported Employment. The Progress Summary should contain at a minimum:

- The participant's name
- Date of the quarterly review and dates that the review covers

- The goals reflected in the current Individual Support Plan
- Progress toward goals
- Recommendations for continuation, revision or termination of an outcome
- Signature of the individual who completed the review

The Progress Summary should be completed quarterly based on the participant's ISP year and should be completed separately for each service. The quarterly progress note shall be documented within seven (7) working days of the close of the quarterly progress period. If a quarterly progress summary is not documented within seven (7) working days of the close of the service period, it shall be considered a "late entry." The documentation shall be noted as a "late entry" and shall include at a minimum the date the documentation was made and the date when the documentation should have been entered. For example, "Late Entry made on 2/14/08 for 2/7/08."

The Qualified Professional or other designated staff (one of whom directly provided the service during the timeframe in which the service was provided) is responsible for gathering all relevant information from the other staff on the team and writing and signing a note that outlines the participant's progress during that service period.

Service Specific Documentation

Assistive Technology Equipment and Supplies

- Assessment/recommendation by an appropriate professional that identifies the participant's need(s) with regard to the equipment/supply being requested.
- Copy of the physician's signature certifying medical necessity is included with the request for equipment/supply. The recommendation must be less than one-year-old from the date the request is received by the PIHP. The assessment confirms medical need for the equipment and identifies the participant's need(s) with regard to specific equipment being requested.
- The estimated life of the equipment as well as the length of time the participant is expected to benefit from the equipment, shall be indicated in the request.
- An invoice from the supplier that shows the date the Assistive Technology Equipment and Supplies were provided to the participant and the cost including related charges (for example, applicable delivery charges) shall be maintained by the PIHP.
- Long-range outcomes related to training needs associated with the participant's/family's utilization and/or procurement of the requested equipment/adaptations are included in the Individual Support Plan as appropriate.
- Specific equipment and supplies in the definition require additional documentation. See Section 13 for these requirements.

Community Guide

Maintain service notes signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals. A daily per event service note should be completed.

Community Networking

- Maintain service note or grid signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and

a description of the activities related to the long-range outcomes and the short-range goals.

- For conferences, classes, and related materials purchased in conjunction with these an invoice will be required.
- For Community Networking Transportation that is not part of the provision of a staffed service with an established per trip rate, maintain a record with a signature of a representative providing the transportation.
- For Community Networking Transportation that is not part of the provision of a staffed service with a per mile charge, maintain a record that documents the date service was provided, the specific activity that the person is being transported to/from, and the mileage related to the transportation of the person. The person providing transportation shall sign the record.

Community Transition Services

Maintain the approved Community Transition Checklist and a copy of invoices from the suppliers that shows the date the community transition services were provided to the participant and the cost of the services.

Crisis Services

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

Home Modifications

- Assessment/recommendation by an appropriate professional that identifies the participant's need(s) with regard to the Home Modification being requested.
- Copy of the physician's signature certifying medical necessity is included with the request for Home Modifications.
- Long-range outcomes related to training needs associated with the participant's/family's utilization and/or procurement of the requested adaptations are included in the Individual Support Plan as appropriate.
- An invoice from the supplier that shows the date the materials or equipment was provided to the participant, and cost including the related changes for example, applicable delivery charges should be maintained by the PIHP.

Individual Directed Goods and Services

An invoice from the supplier that shows the date the good was provided to the participant and the cost including related charges (for example, applicable delivery charges) shall be maintained by the Financial Support Agency or Agency With Choice.

Services will require a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.

Natural Supports Education

Maintain service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goal. For

conferences, classes, and related materials purchased in conjunction with these an invoice will be required.

Respite Service

Respite services shall be documented on a daily basis, and the documentation must contain the following components: Name of the participant, the record number, the service provided, the date of service, duration of service, task performed, including comments on any behaviors, which are considered relevant to the participant's continuity of care, that special instructions were followed; and signature (initials, if the full signature is included on the page when the use of a grid is used for documenting).

Specialized Consultation Services

Maintain Intervention Plan (as applicable), service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.

Vehicle Adaptation

- Recommended equipment or modification shall be justified by an assessment from one or more of the following: Physical Therapist/Occupational Therapist specializing in vehicle modifications; or a Rehabilitation Engineer; or a Vehicle Adaptation Specialist.
- Recommendation by a certified driving instructor for persons with disabilities, if the participant is driving the vehicle to be modified.
- A physician's signature certifying medical necessity for the equipment or modification for the participant.
- The recommendation must be less than one-year-old from the date the PIHP receives the request.
- The estimated life of the equipment as well as the length of time the participant is expected to benefit from the equipment, shall be indicated in the request.
- An invoice from the supplier that shows the date the vehicle adaptation was provided for the participant and the cost including related charges (for example, applicable delivery charges) shall be maintained by the PIHP.
- Long-range outcomes related to training needs associate with the participant's/family's utilization and/or procurement of the requested adaptations are included in the Individual Support Plan as appropriate.

General Records Administration and Availability of Records

NC Innovations service providers will make service documentation available to the Care Coordinator, the PIHP, DMH/DD/SAS, DMA, and/or CMS to review the documentation to support a claim for NC Innovations services rendered, when requested.

The NC Innovations Service Provider maintains records that contain the required information in the Records Management and Documentation Manual (please refer to 45-2, Chapter 2 for the contents of full clinical service record requirements) and the following NC Innovations information:

- Authorization letters for NC Innovations services;
- A copy of the Individual Support Plan, including current long-range outcomes;
- Service documentation required in the section;

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

How Long Records Must Be Kept

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

Individual/Family Directed Services Documentation

Participant's/Families who elect to direct their own services will be required to have the individual workers document services following the above referenced criteria.

For individuals electing the Employer of Record Model, the documentation will be stored in the individual's/family's home. Should the individuals or their families decide to stop self-directing services under the Employer of Record Model, all documentation will be returned to the PIHP. For individuals electing the Agency With Choice Model, the documentation will be stored as directed by the Agency With Choice.

The Quality Management Department at PIHP will conduct annual reviews to include review of service documentation. For additional information regarding documentation for individual/family directed services, please refer to the PIHP Employer Handbook.

Absences, Movement from the PIHP Area and Terminations

This chapter provides information about participant absences, movement of participants to/from the PIHP catchment area, and termination of services.

Absences

If the participant is hospitalized, placed in an ICF-MR facility, admitted to a state psychiatric facility, becomes an inmate in a public correctional institution or will be absent for 30 days or more, DSS will direct the Care Coordinator about continuing Medicaid eligibility.

Hospitalizations

When a participant is admitted to a hospital, the Care Coordinator suspends the delivery of NC Innovations funding with the exception of Treatment Planning Case Management Treatment Care Coordination that may be provided for the purposes of discharge planning up to 60 days prior to discharge, as long as activities do not occur that duplicate the services provided by hospital staff. No NC Innovations Services may be billed to Medicaid for a participant who is hospitalized. The Care Coordinator notifies the service providers of the suspension and the projected resumption date. The length of time the participant is hospitalized determines what else must be done.

- If 30 days or less, there usually are no special actions required beyond the normal tasks of coordinating the temporary changes in services with providers, monitoring the participant's situation, and working with hospital discharge planners and others to assure services and supports upon discharge. The Care Coordinator notifies the DSS Medicaid staff of the admission. Medicaid services, supplies, and equipment cannot be provided or billed to Medicaid during hospitalizations.
- If over 30 days, Medicaid staff are notified. Medicaid staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. This removes the participant from NC Innovations funding. Once the Medicaid staff determines the effective date of the termination, the Care Coordinator follows the termination procedures outlined in this chapter. If the person later wishes to be re-enrolled to NC Innovations, the PIHP and Care Coordinator considers the person a new participant and follows the procedures in Chapters 7 and 10. A participant re-enrolled to NC Innovations within the same Waiver year re-enters the slot that he or she left.

Admission to ICF-MR or Other Institution

When a NC Innovations funding participant is admitted to an ICF-MR/DD facility, nursing facility, or psychiatric institutional setting other than a hospital, the participant must be terminated from NC Innovations on the date of institutionalization. If the person wishes to resume NC Innovations participation upon discharge, the PIHP and Care Coordinator considers the person a new participant and follows the procedures in Chapters 7 and 11.

Temporary Absence from Area

When a participant temporarily leaves the area, the Care Coordinator suspends the delivery of NC Innovations services. The Care Coordinator tracks the length of the absence as extended absences can affect Medicaid eligibility. If the absence is 30 days or more, the Care Coordinator notifies the Medicaid staff. The Medicaid staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be

removed. Once the Medicaid staff determines the effective date of the termination, the Care Coordinator follows the termination procedures outlined on in this chapter.

The use of one waiver service process in Chapter 7 is followed if Medicaid staff does not terminate the participant's NC Innovations funding.

Service Breaks

The participant may miss a service for a variety of reasons. Holidays, family vacations, weather conditions, illnesses, and scheduling conflicts can cause brief interruptions in services. Breaks in service need to be documented by the provider, and monitored by the Care Coordinator. When such an interruption occurs, the service may be rescheduled, depending on the nature of the service missed. Providers should keep in mind the Limits on Sets of Services in Appendix M when determining if services may be rescheduled, especially if multiple providers serve the participant. The provider contacts the Care Coordinator if there are questions regarding the rescheduling of the service. (Refer to Chapter 10 for details about revisions.) The exception to providing services as approved on the plan may not be used if the participant missed services while he or she was ineligible for Medicaid or NC Innovations. Services missed during periods of ineligibility may not be rescheduled. Service breaks do not require Level I Back-Up Staffing Incident Reports.

Movement from NC Innovations to another Part of North Carolina for the purposes of Medicaid Eligibility Where the CAP-MR/DD Waiver Operates:

North Carolina Innovations Waiver participants are legal residents (for the purpose of Medicaid eligibility) of the PIHP Area. When a person moves to another county in the State, and becomes a legal resident of a Local Management Entity (LME) catchment area where the CAP-MR/DD waiver operates, the person is no longer eligible for NC Innovations

- The Care Coordinator contacts DSS to coordinate the Medicaid transfer. DSS determines the effective date of the transfer. The Care Coordinator may also need to assist the family in contacting the Social Security Administration if the participant receives SSI.
- If the transfer will not happen prior to the move, the Care Coordinator will speak with the current provider and see if they are able to provide services in the new county of residence. If not, the Care Coordinator will work with the participant/legally responsible person to select a new provider who can continue the services until the CAP-MR/DD services become effective.
- **It is important that there be no lapse in service for the participant during this process. NC Innovations Wavier participants must use one waiver service per month to continue their eligibility.**
- The Care Coordinator completes the NC *Innovations to CAP- MR/DD Referral Form* with supporting documentation and forwards it to the designated PIHP contact.
- The PIHP contacts the Division of MH/DD/SAS to determine if there is available funding to facilitate movement from NC Innovations to CAP- MR/DD.
- If funding is available, the PIHP refers the participant to the LME where the participant is moving.
- The participant is terminated from NC Innovations by following the termination procedures outlined in this chapter.

- The vacated slot may not be filled by the PIHP until the beginning of the new waiver year. If the participant should move back to the PIHP catchment area (Medicaid changes back to one of the PIHP counties) before the new waiver year begins, the participant would re-enter the waiver in the vacated slot.

See Appendix O for the NC Innovations to CAP-MR/DD Referral Form. The receiving LME can assist the participant to explore funding options for services within their LME if waiver funding is not available. DMA is notified if waiver funding is not available.

Because the PIHP operates under a capitated waiver, the termination date of the NC Innovations Waiver will be the last day of the month following the participant's established residency outside the PIHP catchment area. Entrance to the CAP-MR/DD Waiver is dependent on funding and slot availability.

Movement from CAP- MR/DD to North Carolina Innovations

When a person participating in the CAP-MR/DD Waiver becomes a legal resident (for the purpose of Medicaid eligibility) of the PIHP Area where NC Innovations operates, the participant is no longer eligible for CAP-MR/DD and is referred to the PIHP for services. Entrance into the NC Innovations Waiver depends on funding and slot availability. NC Innovations has a limited number of reserved slots that are designated for the purpose of transition between CAP-MR/DD and the NC Innovations waivers.

- The CAP-MR/DD case management agency contacts DSS to coordinate the Medicaid transfer. DSS determines the effective date of the transfer.
- The CAP-MR/DD case manager completes the *CAP-MR/DD to NC Innovations Referral Form* with supporting documentation and forwards it to the LME contact responsible for developmental disabilities.
- The LME forwards the referral packet to the PIHP.
- The PIHP determines if funding is available, contacting DMA if funding is not available.
- If funding is available, the PIHP notifies the LME who in turn can notify the case management agency and the participant/legally responsible person.
- The PIHP sends a copy of the referral packet to both the Care Coordination Department for Care Coordinator assignment and the PIHP Care Management Department to begin the Level of Care Process.
- The Care Coordinator contacts the sending LME case manager to begin the development of the Individual Support Plan and other needed transitional materials.
- The PIHP works with the Local DSS to verify the effective date of Medicaid transfer.
- Once the ISP is developed and approved, a provider selected, services authorized and Medicaid eligibility has moved to the PIHP area, the participant will begin to receive services through the NC Innovations Waiver.
- The participant is terminated from CAP-MR/DD
- If there is no slot available for the individual, DMA is notified. If after contacting DMA, there is no slot available, the PIHP refers the individual to their Screening and Application process to discuss other available services and to the Registry of Unmet needs.

Because the PIHP operates under a capitated waiver, the effective date of the termination from the CAP-MR/DD Waiver will be the last day of the month following the participant's established residency in the PIHP catchment area.

Appendix O contains the required form that is necessary in referring a participant from CAP-MR/DD to NC Innovations.

Movement from the PIHP (NC Innovations) to another PIHP for the purposes of Medicaid Eligibility Where NC Innovations Waiver Operates:

North Carolina Innovations Waiver participants are legal residents (for the purpose of Medicaid eligibility) of the PIHP Area. When a person moves to another county in the State, and becomes a legal resident of another PIHP region where the NC Innovations waiver operates, the person's becomes a participant in the PIHP where Medicaid has transferred.

- The Care Coordinator contacts DSS to coordinate the Medicaid transfer. DSS determines the effective date of the transfer.
- If the transfer will not happen prior to the move, the Care Coordinator will speak with the current provider and see if they are able to provide services in the new county of residence. If not, the Care Coordinator will work with the participant/legally responsible person to select a new provider who can continue the services until the services in the PIHP where Medicaid will transfer become effective.
- **It is important that there be no lapse in service for the participant during this process. NC Innovations Wavier participants must use one waiver service per month to continue their eligibility.**
- The Care Coordinator completes the *NC Innovations to NC Innovations Referral Form* with supporting documentation and forwards it to the NC Innovations Manager for the PIHP where Medicaid will transfer.
- If funding is available, the PIHP refers the participant to the PIHP where the participant is moving.
- The participant's slot transfers to the receiving PIHP. The transfer, including the slot transfer, is reported by both PIHP's to DMA on the monthly tracking report. The participant **is not terminated** from NC Innovations
- A new NC Innovations Level of Care and Individual Support Plan **are not required**.

See Appendix O for the NC Innovations to CAP-MR/DD Referral Form. The receiving LME can assist the participant to explore funding options for services within their LME if not waiver funding is available.

Because the PIHP operates under a capitated waiver, the transfer date of the NC Innovations Waiver slot will be the last day of the month following the participant's established residency outside the PIHP catchment area.

Terminations

This section provides guidance on terminating a participant from NC Innovations. The termination may be due to a variety of reasons, including ineligibility for Medicaid, moving outside the catchment area, institutionalization, or failure to qualify for program

participation. Depending on the reason for termination, it may be initiated by the county Department of Social Services, the PIHP, or the participant/legally responsible person.

The following material covers the usual types of terminations. Keep the following in mind:

- Terminations must be completed with full regard for the participant's rights, including those related to a fair hearing.
- For most terminations, the effective date is the last date of the month. The exceptions are noted in this chapter.
- All terminations **must** be coordinated with DSS.
- Written notifications of terminations must be sent to the person/legally responsible person, the PIHP and DSS.

DSS Terminates Medicaid Eligibility

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

Individual Support Plan (Plan of Care) is disapproved

If the PIHP does not approve a participant's Individual Support Plan, the Department notifies the Care Coordinator in writing to begin the termination process and reminds the Care Coordinator to coordinate actions with DSS. The PIHP sends a copy of the letter to the Medicaid supervisor in the county DSS. The PIHP notifies the participant /legally responsible party in writing of the termination and the right to appeal the decision. Written notices are also sent to the Provider Agencies, the Employer of Record, Financial Support Agency or the Agency With Choice in the Individual and Family Directed Supports Option to stop services.

If the participant/legally responsible person accepts the decision, the PIHP notifies DSS that the participant is proceeding with the termination. If the participant/legally responsible person wishes to appeal the decision, appeal rights are issued.

Participant Institutionalized or Participant's Level of Care Changes

If the participant is admitted to an ICF-MR or nursing facility or if the participant's Level of Care is changed to Intermediate, Skilled, or Hospital Level of Care on a Level of Care Form, the Care Coordinator terminates the participant on the date of admission or date of change of Level of Care. Also, if the participant is admitted to a hospital for a stay longer than 30 days, the Care Coordinator consults with DSS about possible termination. The Care Coordinator notifies the PIHP. The PIHP:

- Sends written notification of the termination to DSS;
- Informs the person/legally responsible party in writing of the termination; and sends written notification to Provider Agencies, Employers of Record, Financial Support Agencies or Agencies With Choice to stop services;

Participant Moves Out of Area

If the termination of NC Innovations is due to the participant moving out of the state or out of the catchment area to a county where NC Innovations **does not operate**, the termination is usually the last date of the month. The Care Coordinator notifies the PIHP. The PIHP notifies of the termination. Notification of termination must be written. If the person is moving to another county in North Carolina and wishes to continue waiver participation, the Care Coordinator follows the instructions for movement to another catchment in this chapter.

Participant Dies

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

Other North Carolina Innovations Terminations

If the termination is for reasons other than those covered above, the Care Coordinator coordinates the proposed termination date with DSS. The Care Coordinator notifies the PIHP who must give the person at least 10 days written advance notice of the proposed termination. The reason for termination and the participant's appeal rights must be included. The date of termination is the last day of the month of NC Innovations eligibility. When the termination is final, the Care Coordinator notifies the PIHP of the termination in writing. The PIHP notifies Provider Agencies of the termination.

End of Waiver Year Terminations

If termination from NC Innovations is planned so that another person receives the slot the next waiver year (April-March) the NC Innovations indicator on the Eligibility Information System (EIS) for the current participant must be closed effective no later than March 31 of the current year. The effective termination date is the last day of the month of NC Innovations eligibility. To initiate the termination process the PIHP must:

- Notify the Medicaid staff no later than February 28 to allow time to meet the Medicaid advance notices requirements. This cannot be done retroactively.
- Provide at least 10 days advance notice to the participant/legally responsible party with the right to appeal.
- Notifications of terminations must be written.

The Appeals and Grievances Chapter to the NC Innovations Waiver Technical Guide is currently under review by the NC Attorneys General.



Quality Management

The North Carolina Innovations Waiver is a 1915(c) waiver that operates under the umbrella of a 1915 (b) waiver. NC Innovations services are delivered through a prepaid inpatient health plan (PIHP) under the terms of a risk contract. Each waiver type has distinct requirements for quality management that are based on federal laws and regulations and are meant to ensure that the goals and intent of the respective waivers are met. During the initial waiver period, quality management programs and activities for each waiver were developed and implemented separately. PIHP reporting on performance measures and performance improvement projects, an External Quality Review (EQR) contract, and an Independent Assessment contract were implemented in compliance with managed care regulations and 1915 (b) waiver requirements. Quality management activities for the NC Innovations Waiver during the initial waiver period included oversight of the PIHP's implementation of processes and procedures to address 1915(c) waiver assurances, Care Coordinator oversight of plan implementation and service delivery, and record reviews to identify any issues related to meeting assurances. As the services and populations covered by both waivers are interrelated and the infrastructure and processes for PIHP oversight are in place, the goal is to better integrate quality management activities for all PIHP Medicaid services and to begin to focus on quality improvement. At the same time, it will be necessary to ensure that the specific quality management requirements of each waiver type continue to be met.

Performance Measures

As stated above, performance measure reporting related mainly to State Plan MH/DD/SA services through the PIHP has already been implemented. The NC Innovations Waiver application contains 22 performance measures specific to the waiver which will be implemented and reported to the State through similar processes. The PIHP will also revise its reporting on grievances and appeals to identify those made specifically by or on behalf of NC Innovations participants/applicants. Up until now, the reporting has been disability specific in terms of mental illness, developmental disability and substance abuse needs. See Appendix W for the NC Innovations Performance Measures.

Department of Health and Human Services Oversight Processes

DHHS will maintain an Intra-Departmental Monitoring Team (IMT) to provide monitoring and oversight of the PIHP NC Innovations Waiver and the concurrent NC MH/DD/SAS B Waiver. The Monitoring Team will meet a minimum of quarterly and will conduct an annual on-site monitoring review. Members of the Intra-Departmental Monitoring Team will include representation from the PIHP, DMA, DMH/DD/SAS, and other DHHS Divisions. The Intradepartmental Monitoring Team also conducts annual on-site reviews of the PIHP.

The IMT has been active since the waivers were implemented. The IMT has focused heavily on the transition of the PIHP local management entities into a fully functional managed care entities with the capabilities for authorizing and managing services, accurate and prompt payment of claims, developing strong utilization and quality management departments, and becoming data driven in its decision making.

All activities, including analysis of performance measure reporting, findings from IMT and external reviews, analysis of grievances and appeals reports, record reviews by the PIHP and review of provider network for adequacy and choice, will be the basis for an

ongoing corrective action/quality improvement plan. The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress and target dates for completion. The areas for improvement will be prioritized and monitored on a day-to-day basis by the DMA waiver team and the DMA Behavioral Health section. Progress, issues and concerns will be presented to the IMT, which will serve as an advisory committee for the plan.

Through tracking and trending of performance reporting and findings from other oversight activities, DMA and the PIHP expect to be able to identify any provider-specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. As examples, with trending and tracking of complaints: a specific provider might be identified who needs additional training or even termination from the network; recurring and excessive delays in implementing service plans might result in changes in internal assessment/authorization processes; and, as a final example, inconsistencies identified in level of care determinations could result in additional training to assure that staff have the same understanding of level of care criteria.

Progress on the corrective action/quality improvement plan will be presented quarterly to the IMT for comments and guidance. All NC Innovations related monitoring will be summarized and presented to CMS annually through the 372 report process and as requested.

Division of Medical Assistance Oversight Authority

DMA has the right to impose penalties, sanctions, or arrange for temporary management of the waiver, independent of the actions of the Intra-Departmental Monitoring Team as related to DMA's oversight of this waiver. DMA will ensure accountability and effective management of NC Innovations. DMA will retain the responsibilities of approving all policies, rules and regulations concerning NC Innovations and will oversee the operation of this waiver program.

Incident Reporting and Monitoring

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. Applicable Laws and Rules include: North Carolina Statute G.S. 122C and Client Rights Rules, APSM 95-2. Critical Incidents are defined as any happening which is 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. They are reported as Level 1, 2, or 3 Incidents as defined by the State. The definition of incidents includes the use of any restrictive intervention (defined by NC as the use of physical restraint, mechanical restraint, isolation time out, seclusion or protective device used for behavior modification) and all processes outlined below apply to the use of restrictive interventions.

Provider agencies, Employers of Records and Agencies With Choice are required to submit a Quarterly Report of Level 1 Incidents to the PIHP. State Rule requires the PIHP to review and respond to Level 2 and 3 incidents.

Back-Up Staffing

The Back-Up Staffing Plan is designed to meet the needs of the participant to make sure that their health and safety is assured. Failure to provide back-up staffing is considered a Level 1 Incident in the NC Innovations Waiver. A Back-Up Staffing Incident Report

Form, located in Appendix S, is to be completed and submitted to Quality Management Plan. The Back-Up Staffing Incident Report is completed even if the participant/family declines the back-up staff offered to them. The Provider Agency, Employer of Record or Agency With Choice, submits the Back-Up Staffing Incident Report to the Quality Management Department within 72 hours. The Agency, Employer of Record or Agency With Choice is responsible for attending to the health and welfare of the participant, analyzing causes of the incident, and correcting the problems that are identified. The Incident Report includes a description of the incident, how the participant was affected by the lack of staff and service provision, how time was covered and follow-up provided. Follow-up that is provided regarding an incident due to failure to provide back-up staffing should be accompanied by documentation that supports intervention and its effectiveness. The information should be submitted to the PIHP Quality Management Department along with the submission of the incident report.

The Quality Management Department logs in and files Back-Up Staffing Incident Reports. The Department reviews the incident to ensure that any issues that affect the health and safety of a participant are addressed and appropriate follow-up occurs. The Quality Management Department may require additional training and/or a corrective action plan. If the participant's health and safety have been jeopardized by an agency, Employer of Record or Agency With Choice, the Quality Management Department notifies DMA immediately and a plan of action is agreed upon and implemented. The Quality Management Department also notifies the Care Coordinator of Incident Reports where the participant's health and safety have been jeopardized. The Care Coordination Department is also made aware of patterns of failure of agencies, Employers of Record or Agencies With Choice to provide back-up staffing.

Back-Up Staffing Incident Reports are not included in the Quarterly Incident Report Summary submitted to the Quality Management Department.

Glossary

1915(c) – The provision of the Social Security Act that authorizes the Secretary of HHS to grant waivers to certain Medicaid statutory requirements so that a state may furnish home and community based services to Medicaid beneficiaries who need a level of institutional care that is provided in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR)

1915(b) – A provision of the Social Security Act that authorizes the Secretary of HHS to grant certain waivers of Medicaid statutory requirements. The 1915(b) authority may be used to: mandate the enrollment of Medicaid beneficiaries into managed care plans, employ a central enrollment broker, use cost savings to provide additional services to Medicaid recipients and/or limit the number of providers through selective contracting. A waiver effective under the provision of 1915(b) may be effective for a period of two years and may be renewed for subsequent two-year periods.

1915(b)(c) Concurrent waivers – The simultaneous use of the 1915(b) and 1915(c) waiver authorities to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) authority to limit freedom of choice, and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, states can provide long-term services and supports in a managed care environment or use a limited pool of providers. A state can implement concurrent waivers as long as all federal requirements for both waiver programs are met.

Access Center – Access management is a critical function of the PIHP. The PIHP is responsible for timely response to the needs of consumers and for quick linkage to qualified providers in the network. The PIHP maintains a 1-800 call system to receive all inquiries. This includes information, access to care, emergency, and network provider assistance.

Action - In the case of an MCO or PIHP— (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Activities of Daily Living (ADL's) – Basic personal everyday activities that include bathing, dressing, transferring, toileting, mobility and eating.

Agency – An Area Facility as defined by 122C-3 subsection 14A. An Agency may deliver a number of services, submit and bill claims under a tax ID number.

Agency With Choice –An Individual/Family Directed Service Model that is made available to waiver participants who choose to direct some or all of their services. Also known as the “co-employment option,” an arrangement wherein an organization (a co-employment agency) assumes responsibility for: (a) employing and paying workers who have been selected by waiver participants to provide services to them; (b) reimbursing allowable services; (c) withholding, filing and paying Federal, state and local income and

employment taxes; and, (d) sometimes providing other supports to the participant. Under this model, the participant acts as the “Managing Employer” and is responsible for hiring, managing, and possibly dismissing the worker. The Agency With Choice model can enable participants to exercise choice and control over services while relieving them of the burden of carrying out financial matters and other legal responsibilities associated with the employment of workers. Under this model, the co-employment agency is considered the common law employer of workers who are recommended for hire by the waiver participant.

Adult Developmental Vocational Program (ADVP) – A service providing vocational training and developmental activities for adults with developmental disabilities.

Alternative Family Living Arrangement (AFL) - An out of home setting where the participant receives 24-hour care and lives in a private home environment with a family (or individual) where the services are provided to address the care and habilitation needs of the participant. Any AFL providing services to a child/children or two or more adults requires a license (as defined by NC General Statutes 122C-3 27G .5600F). Waiver funding may not be utilized as payment for room and board costs.

Americans with Disabilities Act (ADA) – A law that prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.

Annual Plan – The 12-month period for the Annual Plan/ISP year that runs from the first day of the month following the birth month to the last day of the month of the birth month.

Appeal – A request for review of an action, as “action” is defined in this glossary.

Approved Plan of Care – Refers to an approved Individual Support Plan.

Assessment – One or more processes that are used to obtain information about a participant, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a participant requires waiver services as well as the development of the service plan.

Authorized Services – Medically necessary services approved by the PIHP.

Back-Up Staffing – Provision for alternative arrangements for the delivery of services that are critical to participants well-being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them.

Best Practices – Recommended practices, including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results, as well as Emerging Practices for which there is preliminary evidence of effectiveness in treatment.

Budget Authority – The participant direction opportunity through which a waiver participant exercises choice and control over a specified amount of waiver funds (Participant-Directed budget). Under the budget authority, the participant has decision-making authority regarding who will provide a service, when the service will be provided,

and how the service will be provided consistent with the waiver's service specifications and other requirements. The participant has the authority to make changes in the distribution of funds among the waiver services included in the Participant Directed budget. Budget changes and the service plan must be synchronized.

CAP – The acronym for the State of North Carolina's Home and Community Based 1915-C Waivers, which provide an alternative to institutional care.

CAP/C – The acronym for the Community Alternatives Program for Children – a program that offers home care for medically fragile children who otherwise would require hospital or nursing facility care.

CAP/Choice – The acronym for the Community Alternatives Program for Disabled Adults who choose Participant Direction.

CAP/DA – The acronym for the Community Alternatives Program for Disabled Adults – a program that provides home care for adults who otherwise would require nursing facility care.

CAP- MR/DD – The acronym for the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities, the waiver that provides home and community-based care as an alternative to care in an intermediate care facility for persons with Intellectual/Developmental Disabilities (ICF-MR) for individuals who are legal residents of counties outside the PIHP catchment areas.

Care Coordination — The PIHP department that employees or contracts for the Care Coordinators who deliver Treatment Planning Case Management services.

Care Coordinator – the individual who provides Treatment Planning Case Management Services in the NC Innovations Waiver

Care Management – Care Management is non-face-to-face monitoring of an individual consumer's care and services, including follow-up activities, as well as assistance to consumers in accessing care and non-plan services, including referrals to providers and other community agencies.

Caregiver – A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends, or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.

Case Management - Assistance in gaining access to and coordination of needed rehabilitation, habilitation, medical, social, educational, and other medically necessary services. Activities include:

- assessment of the eligible individual to determine service needs
- development of a specific care plan
- referral and related activities to help the participant obtain needed services,
- monitoring and follow-up

In the NC Innovations Wavier Treatment Planning Case Management Care Coordination is provided to the participant.

Catchment Area – Geographic Service Area meaning a defined grouping of counties.

Capitation Payment – A method of payment for an array of services wherein a single fixed payment is made periodically (usually monthly) to a provider (e.g., a managed care entity) on behalf of each beneficiary who is enrolled with the provider and for whom the provider is obligated to furnish the services included in the array. The state makes the payment regardless of the actual number or nature of the services provided. Capitation payment methods are commonly employed in managed care arrangements.

C.F.R. – Code of Federal Regulations

CMS – The acronym for the Centers for Medicare and Medicaid Services, the Federal agency that administers Medicare and Medicaid for the Federal government.

Co-payment – The amount that a Medicaid recipient is responsible for paying for certain services, such as prescriptions and physician visits. CAP recipients do not pay co-payments.

Common Law Employer – A common law employer-employee relationship generally exists when the person for whom services are performed has the authority to control and direct the individual who performs the services, not only as to the result to be accomplished but also as to the detail and means by which that result is accomplished.

County DSS – The county Department of Social Services: the local agency that determines Medicaid eligibility, eligibility for other assistance programs, and provides a variety of services in the county.

Criminal Background Check – A process that is undertaken to determine whether a person who would provide services has been convicted of a crime. Requirements for conducting criminal history/background investigations are typically established under state law/regulations. Under such requirements, a human services agency or health care provider must conduct an investigation prior to hiring a person or permitting an employee to furnish services directly to participants and, in some cases, may prohibit the employment of participants who have been convicted of specified crimes.

Crisis Plan – A Crisis Plan is an individualized written plan developed in conjunction with the consumer and treatment team. The plan contains information to assist in de-escalating a crisis as well as clear directives to the individual crisis workers or others involved, crisis plans are developed for consumers at risk for inpatient treatment, incarceration, or out-of-home placement.

Deductible – see Medicaid Deductible.

Deeming – A Medicaid eligibility term that refers to considering the income and/or resources of a Medicaid applicant's parent(s) or spouse as available to the applicant.

The income or resources are "deemed" to be available to help meet the applicant's needs.

Denial of Service – A determination made by the PIHP in response to a Network Provider's request for approval of services of a specific duration and scope which:

- Disapproves the request completely; or
- Approves provision of the requested services(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested service which includes a requirement for a concurrent review by the PIHP during the authorized period does not constitute a denial); or
- Disapproves provision of the requested service(s), but approves provision of an alternative service(s).

Deinstitutionalization – The reduction in the number of participants residing in institutions. For Innovations purposes, it also includes movement from a community ICF-MR group home.

Developmental Day Center – A day program designed to provide habilitative services to children with developmental disabilities.

Developmental Disabilities (DD) – A severe chronic disability of a person which:

- Is attributable to a mental or physical impairment or combination of mental or physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning mobility, self-direction and economic self-sufficiency.

Discovery – Engaging in activities to collect data about the conduct of processes, the delivery of services, and direct participant experiences in order to assess the ongoing implementation of a waiver, identifying both concerns as well as other opportunities for improvement. Examples of discovery activities include, but are not limited to, monitoring, complaint systems, incident management systems, and regular systematic reviews of critical processes such as participant-centered planning and level of care determinations. Discovery activities are usually designed to identify problems that may require remediation and sometimes lead to systemic changes/improvements.

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

DHHS – North Carolina Department of Health and Human Services.

DMA – The acronym for the North Carolina Division of Medical Assistance located in the Department of Health and Human Services. This is the agency that operates the Medicaid program for North Carolina. DMA administers the NC Innovations Waiver and the NC MH/DD/SAS Health Plan.

DME – The acronym for durable medical equipment.

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

DOS – The acronym for date of service: the date that a service is provided to a Medicaid recipient.

DSS – An acronym used in two ways. Depending on the context, it may refer to the North Carolina Division of Social Services in the Department of Health and Human Services. This is the agency that administers public assistance programs (other than Medicaid) and service programs for children and adults. It may also refer to the county department of social services located in each county in the State.

Eligibility – The determination that an individual meets the requirements to receive services as defined by the payer.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Medicaid's comprehensive child health program for individuals under the age of 21. EPSDT is authorized under §1905(r) of the Act and includes the performance of periodic screening of children, including vision, dental, and hearing services. §1905(r)(5) of the Act required that any medically necessary health care service that is listed in §1905(a) of the Act be provided to an EPSDT beneficiary even if the service has not been specifically included in the State plan. Federal EPSDT regulations are located in 42 CFR §441.50 *et seq.*

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

EPSDT – See Early and Periodic Screening, Diagnosis and Treatment.

Fair Hearing – The administrative procedure established in §1902(a)(3) of the Act and further specified in 42 CFR Subpart E (42 CFR §431.200 through §431.246) that affords individuals the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter. An individual has the opportunity to request a Fair Hearing when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.

Fee-for-Service – A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to recipients

based on the payment methods set forth in the State plan and the applicable policies and procedures of the Division.

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

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

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

Grievance Procedure – The written procedures pursuant to which participants may express dissatisfaction with the provision of services by the PIHP and the methods for resolution of Enrollee complaints by the PIHP.

Habilitation – Services that are provided in order to assist a participant to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of a participant. Habilitation is contrasted to rehabilitation, which involves the restoration of function that a person has lost.

HCBS – The acronym for home or community-based services. HCBS means services not otherwise furnished under the State's Medicaid Plan that are furnished under a waiver granted by CMS under Section 1915(c) of the Social Security Act.

Health Assessment – The systematic collection of subjective and objective information used to determine the client's health status and need for medical care in relation to developmental, physiological, preventive, and psychological life processes.

Hearing – A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DMA shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

HIPAA – is the acronym for the Health Insurance Portability and Accountability Act of 1996.

HIT – The acronym for Medicaid's coverage of home infusion therapy. HIT coverage includes enteral therapy (EN), total parenteral therapy (TPN), antibiotic therapy, pain management therapy and chemotherapy for cancer. See the Medicaid Community Care Manual for details.

Home Care Agency – An agency that is licensed by DFS to provide home care services and directly related medical supplies and appliances to an individual at his/her home. Home care services include nursing care; physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation, or ventilation.

Home Care Licensure Rules – The regulations for the licensing of home care agencies in NCAC Title 10: Chapter 3, Subchapter 3L that are administered by DHSR. Licensure subjects all home care agencies to meet certain basic requirements relating to the structure of the agency, personnel qualifications and supervision, client rights, client records, quality assurance and functions of various types of personnel.

Home Health Agency – An agency that is Medicare-certified and licensed by DHSR to provide home care services and medical supplies. See the Medicaid Community Care Manual for additional information about covered home health services.

Homebound – The term used to describe the status of a person in regard to the person's ability to leave home. It relates to eligibility for Home Health Services. See the Medicaid Community Care Manual for details.

Hospice – Medicaid's all-inclusive coverage of care related to a patient's terminal illness or a provider of this care, depending upon its use in the sentence. When used in this Guide to designate a provider of Hospice care, it refers to an agency that is Medicare-certified and licensed by DFS to provide hospice care. See the Medicaid Community Care Manual for details.

ICF-MR – The acronym for Intermediate Care Facility for Persons with Mental Retardation; a licensed facility that provides care and treatment for individuals with mental retardation and certain developmental disabilities.

IDEA – The Individuals with Disabilities Education Improvement Act of 2004

IEP – The acronym for Individualized Education Program which is developed in a meeting that includes the child's parent(s), the child (when appropriate), one regular education teacher, one special education teacher, a representative of the local education agency, an individual who can interpret evaluation results, and others with special expertise about the child.

IFSP – The acronym for Individualized Family Service Plan.

IN Indicator – The initials in the CAP block on the Medicaid ID card that identifies the individual as a participant in the Community Alternatives Program for Persons with Intellectual /Developmental Disabilities.

Incident – an unusual occurrence as defined in APSM 30-1. Incidents are reported as Level I, Level II, or Level III as defined in APSM 30-1.

Individual Budget Amount – As used in the waiver application, the term “Individual Budget amount” means a prospectively-determined amount of funds that the state makes available for the provision of waiver services to a participant. The IBA may encompass all waiver services or a subset of waiver services. An IBA may serve as the basis for but is not necessarily synonymous with the term “Participant Directed budget” when a waiver provides for the Budget Authority participant direction opportunity.

Initial ISP Plan of Care Year – Describes the 12-month period used for planning services on the Initial Plan of Care. It begins the month of the NC Innovations effective date and ends 12 months later. For example, if the NC Innovations effective date is in November, the participant’s ISP year is November through the following October.

Individual/Family Direction – The name for Participant Directed Services in the NC Innovations Waiver Provision of the opportunity for a waiver individual to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

Institution – In the context of the waiver application, a hospital, nursing facility or ICF/MR for which the state makes Medicaid payment under the State plan.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) – A public or private facility that provides health and habilitation services to individuals with mental retardation or related conditions (e.g., cerebral palsy). The ICF/MR benefit is an optional Medicaid service that is authorized in §1905(d) of the Act. ICF/MR facilities have four or more beds and must provide active treatment to their residents.

LEA – The acronym for the Local Education Agency (i.e., school system).

Least Restrictive Environment – The least restrictive/intensive setting of care sufficient to effectively treat a consumer.

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

LME/Local Management Entity – a local political subdivision of the state of North Carolina as established under General Statute 122C.

LPN – The acronym for Licensed Practical Nurse. In this Guide, it refers to a practical nurse licensed to practice in North Carolina.

Medicaid – The joint federal and state program to assist states in furnishing medical assistance to eligible needy persons. Federal law concerning the Medicaid program is located in Title XIX of the Act. Within broad national guidelines established by federal

statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, durations, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program.

Medicaid Deductible ("Deductible") – The amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service. See Chapter 6 for details.

Medicaid Identification (MID) Card – The Medical Assistance Eligibility Certification card issued by DMA to Recipients eligible for Medicaid coverage. See Chapter 5 for details.

Medicaid for Infants and Children (MIC) – A program for medical assistance for children under the age of 19 whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid for Pregnant Women (MPW) – A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category. This is part of the Baby Love Program.

Medical Assistance (Medicaid) Program – DMA's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. se.

Medical Record – A single complete record, maintained by the Provider of services, which documents all of the treatment, plans developed for and behavioral health services received by the participant.

MID – The acronym for Medicaid Identification Number; the individual identification number assigned to each Medicaid recipient. It consists of nine digits and an alpha suffix.

MIS - Management Information System.

MQB – The acronym for Medicare Qualified Beneficiaries. Medicaid covers out-of-pocket Medicare expenses for persons who are entitled to Medicare Part A under the Social Security Administration's guidelines and who meet the income and resources requirements of the program. It will not pay for any medical service that Medicare does not cover or any expense not related to Medicare coverage.

Natural Resource Linking – Processes that maximize the use of family and community support systems to optimize functioning.

NCAC – The acronym for the North Carolina Administrative Code; the state regulations.

Network Provider – A provider of behavioral health services that meets the PIHP's criteria for enrollment, credentialing and/or accreditation requirements and is under written agreement to provide services.

North Carolina Innovations Waiver – The 1915 (c) Home and Community Based Waiver that provides support and care for people with intellectual and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR) who are legal residents of the counties that are a part of the PIHP catchment area. NC Innovations can also provide funding for people to return to their home and communities from ICF-MRs.

North Carolina Innovations Effective Date – The date that the participant's coverage for NC Innovations Waiver services begins. It is the latest of three dates:

- The Medicaid application date;
- The NC Innovations Level of Care approval date
- The date of deinstitutionalization

North Carolina Innovations Indicator – The initials (IN) in the CAP block on the Medicaid ID card that identifies the individual as a participant in the NC Innovations Waiver

North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan) – A 1915(b) Medicaid Managed Care Waiver for Mental Health and Substance Abuse allowing for a waiver of freedom of choice of providers so that the PIHP can determine the size and scope of the provider network. This also allows for use of Medicaid Funds for alternate services.

OT – The acronym for occupational therapy or occupational therapist, depending upon its use in the sentence. When used in this Guide to designate an occupational therapist, it refers to one licensed to practice in North Carolina.

Participant – a person who is approved to receive services under the NC Innovations Waiver.

Participant Directed Budget – An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Sometimes call the “Individual Budget.”

Participant Directed Service – A waiver that the state specifies may be directed by the participant using the Employer Authority, the Budget Authority or both.

Participant Direction – Provision of the opportunity for a waiver participant to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

PCS – The acronym for Personal Care Services – a home care service that provides in-home aide services to meet the individual's medically related personal care needs. (See the Medicaid Community Care Manual for details.)

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

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

Primary Care Provider (PCP) – A licensed medical practitioner responsible for supervising, coordinating and providing initial and primary care to a member, for initiating referrals for specialist care, and for maintaining the continuity of patient care; a General Medical Practitioner, an Internist, a Pediatrician, an Obstetrician/Gynecologist, a Family Practitioner, a Physician's Assistant, or a Family Nurse Practitioner. For children with special health care needs, a specialist may perform as a Primary Care Physician.

Primary Diagnosis – The most important or significant condition of an individual at any time during the course of treatment in terms of its implications for the individual's health, medical care and need for services.

Prior Authorization – The act of authorizing specific services before they are rendered.

Provider Network – The agencies, professional groups, or professionals under contract to the PIHP that meet PIHP standards and that provide authorized Covered Services to eligible and enrolled persons.

PT – The acronym for physical therapy or physical therapist, depending upon its use in the sentence. When used in this manual to designate a physical therapist, it refers to one licensed to practice in North Carolina.

QP/Qualified Professional – Any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (NC General Statute 122C-3)

Quality Assurance/Quality Improvement – The process of assuring that health care services provided to Enrollees are appropriate, timely, accessible, available and medically necessary.

Reconsideration Review – An informal session before a DMA Hearing Officer and Medical Policy Director wherein an Enrollee, affected by an action or an intended action by the PIHP, shall be allowed to present and discuss information as to why such action should or should not be taken, and described more specifically in NCAC T10: 22H (for

Enrollees) and NCAC T10: 22J (for the PIHP). The decision of the Hearing Officer is subject to appeal through the Office of Administrative Hearings (OAH).

RN – The acronym for Registered Nurse. In this manual, it refers to a registered nurse licensed to practice in North Carolina.

Slot – The term used by DMH/DD/SAS and in reference to the annual allocation of the number of individuals that may be served in NC Innovations. CMS allows North Carolina to serve a given number of individuals each waiver year in NC Innovations. DMH/DD/SAS refers to this allocation as the number of slots available for the year.

Service Location – Any location at which a participant obtains any Covered Services from a PIHP Provider.

State – State of North Carolina.

State Plan – The State Plan submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS.

Social Security Income – Also referred to as SSI. It is direct, monthly cash payments to provide minimum income for individuals who meet financial needs test and are elderly, blind, or have a disability.

Spend down – Medicaid term used to indicate the dollar amount of charges a Medicaid consumer must incur before Medicaid coverage begins during a month. (See deductible.)

Third-Party Billing – Services billed to an insurance company, Medicare or another agency.

TPL/Third Party Resource – Any resource available to a member for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Act, including but not limited to, insurers, tortfeasors, and worker's compensation plans.

Utilization Management – The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

Utilization Management Authorization - The process of evaluating the medical necessity, appropriateness and efficiency of behavioral healthcare services against established guidelines and criteria and to ensure that the client receives necessary, appropriate, high quality care in a cost effective manner.

Utilization Review – A formal review of the appropriateness and medical necessity of behavioral health services to determine if the service is appropriate, if the goals are being achieved, or if changes need to be made in the Person Centered Plan or services and supports provided.

Waiver – The home and community-based services waivers granted by the Centers for Medicare and Medicaid Services that allows North Carolina to operate the Community Alternatives Programs and NC Innovations Waivers. (See Chapter 1 for details).

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

Who to Contact

- For information about services, programs, claims issues, prior approval, and other related issues that goes beyond what is provided in this manual. Please review the manual before calling for information.
- To get forms and other printed material.
- To determine claims status, Medicaid and MID numbers.
- To report possible fraud and program abuse, possible licensure violations and recipient insurance information.

For information about:	Contact
Access and Enrollment into services and the NC Innovations Waiver	Contact the PIHP Toll Free Number
Authorization of Services for NC Innovations	Contact the PIHP
Case Management for NC Innovations and the NC MH/DD/SAS Plan	Contact the PIHP
Provider Enrollment, Network Management, Provider Relations, Contract Information	Contact the PIHP
Claims Adjustments and Inquiries	Contact the PIHP
Claims Status and Tracking	Contact the PIHP
Claims Submission	Contact the PIHP
Level of Care Assessment for NC Innovations and ICF-MR's	Contact the PIHP
Fraud and Program Abuse Reporting	Program Integrity 919-814-0000, DMA 919-855-4800 and the PIHP
Medicaid Deductibles	Participant's county department of Social Services
Medicaid Eligibility	Participant's county department of Social Services
Medicaid Eligibility Requirements	Participant's county department of Social Services
Recipient Insurance Information	County Department of Social Services

To obtain forms, manuals and other materials:

To Get:	Contact:
DMH/DD/SAS Manuals	Communication and Training Section, DMH/DD/SAS – 3002 Mail Service Center Raleigh, NC 27699-3022, 919-420-7995. Manuals are available on the web at http://www.ncdhhs.gov/mhddsas/statpublications/Manuals/index.htm
CMS-1500's	HP Enterprise Services Provider - at 919-851-8888 or 1-800-688-6696 http://www.ncdhhs.gov/dma/provider/billing.htm
List of Required Manuals for NC Innovations Waiver Provider Enrollment	Contact the PIHP
Level of Care Forms	Contact the PIHP
DMA Fair Hearing Letter	Contact the PIHP

NC Innovations Services

Service	Individual/Family Directed	Provider Directed
Assistive Technology Equipment and Supplies		x
Community Guide Services	x	x
Community Networking Services	x	x
Community Transition Services		x
Crisis Services		x
Day Support Services		x
Financial Support Services		x
Home Modifications		x
In-Home Intensive Supports	x	x
In-Home Skill Building	x	x
Individual Goods and Services	x	
Natural Supports Education	x	x
Personal Care	x	x
Residential Support Services		x
Respite Services	x	x
Specialized Consultative Services		x
Supported Employment Services	x	x
Vehicle Modifications		x

Note: Treatment Planning Case Management Services (Care Coordination) will be provided to individuals participating in the NC Innovations Wavier.

Client: _____

Record Number: _____

**Initial Level of Care Eligibility Determination
NC Innovations**

☐ Prior Approval ☐ Utilization Review

Name _____		
Last _____	First _____	Middle _____
Address _____		
Date of Birth _____ Gender _____		
County of Medicaid Eligibility _____		
MID# _____ Address _____		
Legally Responsible/Guardian _____		
Phone # _____		
Address _____		
1. Living in ICF-MR Facility ☐ Yes ☐ No		
2. Diagnosed condition(s) that establish(es) the individual's developmental disability		
Diagnosis:		
☐ Intellectual Disability (IQ or % of Developmental Delay) _____		
☐ Medical Condition: _____		
☐ Related Condition: _____		
Was the disability manifested prior to age 22? ☐ Yes ☐ No		
Is the disability likely to continue indefinitely? ☐ Yes ☐ No		
Current substantial functional limitations: (Based on functional assessment)		
i. Self Care	☐ Yes	☐ No
ii. Understanding/Use of Language	☐ Yes	☐ No
iii. Learning	☐ Yes	☐ No
iv. Mobility	☐ Yes	☐ No
v. Self-direction	☐ Yes	☐ No
vi. Capacity for Independent Living	☐ Yes	☐ No
The individual could benefit from services and supports to promote the acquisition of skills, and to decrease or prevent regression. ☐ Yes ☐ No		
6. Level of Care Recommendation:		
☐ Eligible ICF-MR ☐ Not Eligible ICF-MR		
Psychologist/Licensed Psychological Associate _____		Date: _____
Physician _____		Date: _____
(MCO USE ONLY)		
ICF/MR Level of Care Approved: _____ Denied: _____		
LOC Effective Date: _____		
Prior Approval Number _____		
_____ UM Clinical Care Manager/Signature/Date		
_____ Medical Director Signature (if applicable) Date		

NC MH/DD/SAS Health Plan
NC Innovations Waiver

Instructions for Level of Care Determination

This form is to be used for prior approval and utilization review of ICF-MR level of care.

Demographics

1. Name-Print last name, first name, middle initial. If no middle name or initial, use NMN.
2. Address-Enter the complete address where the person lives.
3. Date of Birth-Enter the month, day and year.
4. Gender-Enter a capital F to indicate Female or a capital M to indicate Male.
5. County of Medicaid Eligibility-List the county from which the person's Medicaid originates per the SIPPS system.
6. Medicaid Number-Enter the Medicaid Number assigned to the person.
7. Legally Responsible Person/Guardian-List the name of the person who is the legal guardian or responsible person for the individual who is being reviewed.
8. Address of Legally Responsible Person/Guardian-Enter the complete address where the Legal Guardian/Responsible person lives.

Living in ICF-MR facility

1. Place a check in the space indicating whether or not the person lives in an ICF-MR residential facility.

Diagnostic Information

Check all of the disability areas that apply based on the documented disability.

1. Check if the person has Mental Retardation/Intellectual Disability based on the documented assessment and document the IQ or the percentage of developmental delay.
2. Check if the person has a Medical Condition and list the condition based on the documented assessment. If no diagnosis, list NA.
3. Check if the person has a condition closely related to Mental Retardation based on the documented assessment and list the condition. If no diagnosis, list NA.
4. Check the appropriate box to address if the person could benefit from Skill Acquisition.

Was the Disability manifested before the age of 22?

Based on documented assessment, please check the correct box.

Is the disability likely to continue indefinitely?

Based on documented assessment, please check the correct box.

Current Substantial Functional Limitations

Place a check in the **Yes** box for each functional deficit the individual has based on documented assessment. If the individual does not have functional deficits in a specified area then check **No**.

Skill acquisition

Check the appropriate box to address if the person could benefit from Skill Acquisition.

Level of Care Certification

Based on assessment check the appropriate box to designate if the person meets the ICF-MR level of care. Get the Signature and Printed Name of a Licensed Psychologist/Psychological Associate or Physician as appropriate based on who completed the assessment.

Level of Care Recommendation

1. Based on review of information, check approved or denied for ICF-MR Level of Care
2. List the month/day/year that the Level of Care became effective
3. Document the Prior Approval Number
4. Get the signature of the UM Clinical Care Manager and date of signature
5. Get the signature of Medical Director and date of signature if needed.

NC INNOVATIONS MEDICAL ASSESSMENT

Individual's Name: _____		Waiver: _____	
I. System Disorder/Name of Condition		Circle One:	
a. Respiratory		Yes	No
b. Cardiovascular		Yes	No
c. Gastro-Intestinal		Yes	No
d. Genito – Urinary		Yes	No
e. Neurological		Yes	No
f. Other		Yes	No
II. History of Seizures (Type)			
Simple Partial (Simple motor movements/no awareness loss)		Yes	No
Complex Partial (Loss of Awareness)		Yes	No
Generalized – Absence (petit mal)		Yes	No
Controlled with medication		Yes	No
Other: _____			
Seizure Frequency per month: _____			
III. Disability			
Cerebral Palsy		Yes	No
Mental Illness		Yes	No
Other Related Condition: _____			
IV. Sensory/Motor Limitation			
Hearing		Yes	No
Vision		Yes	No
Ambulatory		Yes	No
Fine Motor Deficit		Yes	No
Major Motor Deficit		Yes	No
Communication		Yes	No
V. Treatment Modality			
Physical Therapy		Yes	No
Occupational Therapy		Yes	No
Speech Therapy		Yes	No
Special Diet Type: _____		Yes	No
Other: _____		Yes	No
(IV, Tube Feed, O2, Catheter, etc.) Supportive			
Protection Devices: _____		Yes	No
VI. Medications:			
Individual can self medicate:		Yes	No
Medication	Dosage/Route/Frequency	Related Diagnosis	
VII. Physician Signature			
_____ Physician Name (Print)	_____ Physician Signature	_____ Date	

Medication (Name)	Dosage/Route/Frequency	Related Diagnosis or Condition

Physician Orders:

To be Medicaid certified at the ICF-MR level-of-care, the individual must:

Require active treatment necessitating the ICF-MR 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

Have a diagnosis of mental retardation, or a condition that is closely related to MR:

A. Mental retardation 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.

B. Persons with closely related conditions refer to individuals who have a severe, chronic disability that meets ALL of the following conditions:

1. Is attributable to:
 - a. cerebral palsy or epilepsy or
 - b. any other condition, other than mental illness, that is closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to mentally retarded persons;
2. It is manifested before the person reaches age 22;
3. Is likely to continue indefinitely; and
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. self-care (the ability to take care of basic life needs for food, hygiene, and appearance)
 - b. understanding and use of language (the ability to both understand others and to express ideas or information to others either verbally or nonverbally)
 - c. learning (the 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 have the ability to make decisions necessary to protect one's self)
 - f. capacity for independent living (age appropriate ability to live without extraordinary assistance)

Functional Limitations As Defined By Developmental Disabilities Act

The federal government has defined developmental disabilities as disabilities that are chronic and attributable to mental and/or physical impairments, which are evident prior to age twenty-two. Such disabilities tend to be lifelong and result in substantial limitations in three or more of the following major life activities:

- a. **Self-Care:** Daily activities that enable a person to meet basic life needs for eating, hygiene, grooming, health and personal safety. A substantial limitation occurs when a person needs assistance at least one-half the time for one activity, or needs some assistance in more than one-half of all activities normally required for self-care. Assistance is usually in the form of the intervention of another person directly or indirectly by prompts, reminding and/or supervising someone.
- b. **Receptive and Expressive Language:** Communication involving both verbal and nonverbal behaviors that enable the person both to understand others and to express ideas and information to others. The concept of language includes reading, writing, listening and speaking as well as the cognitive skills necessary for receptive language. A substantial limitation occurs when a person is unable to effectively communicate with another person without the aid of a third person, a person with a special skill, or a mechanical device, or is unable to articulate thoughts and/or to make ideas and wants known.
- c. **Learning:** General cognitive competence and ability to acquire new behaviors, perceptions and information and to apply previous experience in new situations. When a person requires special intervention or special programs to assist that person in learning a substantial limitation occurs. Children who meet the eligibility standard for infant/toddler or special education services or need significant special interventions such as assistive devices or special testing procedures in regular education programs in order to learn would have a functional limitation in learning.
- d. **Mobility:** Motor development and ability to use fine and gross motor skills. A substantial limitation occurs when the ability to use motor skills requires assistance of another person and/or a mechanical device in order for the person to perform age appropriate skills in two skill areas, or to move from place to place inside and/or outside the home.
- e. **Self-Direction:** Ability to make independent decisions regarding and to manage and control one's social and individual activities and/or in handling personal finances and or protecting one's own self-interest. A substantial functional limitation occurs when a child is unable, at an age appropriate level, to make decisions and exercise judgment, behave in a socially acceptable manner, and/or act in his/her own interest. An adult may require direct or indirect assistance such as supervision by another person or counseling to successfully utilize these skills.
- f. **Capacity for Independent Living:** Maintain a full and varied life in one's own home and community. A child who is unable, at an age appropriate level, to assist with household chores, maintain appropriate roles and relationships with the family, use money, and/or use community resources has a substantial functional limitation in this are. The child requires more assistance to perform these activities than a typical child of the same chronological age. An adult displays a significant functional limitation when he/she requires assistance in the activities more than half the time.

(Insert name of PIHP)

NORTH CAROLINA DIVISION OF MENTAL
HEALTH, DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

Client:

Record Number:

PARTICIPANT RESPONSIBILITIES NORTH CAROLINA INNOVATIONS WAIVER

I understand that enrollment in the North Carolina (NC) Innovations waiver is voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded (ICF-MR). My Medicaid eligibility must continue to come from a county in a North Carolina Innovations area for me to continue to be eligible for the NC Innovations waiver and I must continue to meet all other waiver eligibility criteria.

- I understand that by accepting NC Innovations waiver funding that I am in need of waiver services to prevent an immediate need for ICF-MR facility services.
- I understand that to maintain my eligibility for this waiver I require the provision of **at least one waiver service monthly** and that failure to use a waiver service monthly will jeopardize my continued eligibility for the NC Innovations waiver. The services approved in my Individual Support Plan have been determined necessary to improve/support my disability.
- I understand that participants in the NC Innovations waiver live in private homes or in residential facilities licensed for 6 or fewer beds **and** if living in a facility the facility must also meet the home and community characteristics defined in the waiver. If I am currently a participant in NC Innovations or am transitioning to NC Innovations from CAP-MR/DD, my Care Coordinator has explained to me how these requirements apply to my current living arrangement.
- I understand if I choose to move to a facility during my participation in the waiver that is larger than 6 beds or does not meet the home and community characteristics defined in the waiver, I will no longer be eligible for the waiver.
- I understand that the total of my waiver services cannot exceed \$135,000 when I enter the waiver.
- I understand that at any time during my plan year, the total of my waiver services cannot exceed \$135,000 or I will no longer be eligible for the waiver.
- I understand if I select the NC Innovations waiver, I will have an Individual Support Plan (ISP) developed that reflects services to meet my needs. My Care Coordinator will explain the planning process and the establishment of my Individual Budget to me. My ISP will be re-developed annually prior to my birth

month. I understand the NC Innovations waiver will deliver services according to my ISP.

- I understand that I may be required to pay a monthly Medicaid deductible if that is part of my financial eligibility for waiver services. My Care Coordinator can assist me in obtaining information on Medicaid deductibles from my local Department of Social Services.
- I understand that I will cooperate in the assessment process to include but not be limited to Supports Intensity Scale (no less frequently than every 2 years), NC Innovations Risk/Support Needs Assessment, and Level of Care. The NC SNAP may be used in lieu of the Supports Intensity Scale during the initial years of my participation in the NC Innovations waiver. The decision of when the SNAP is used in lieu of the SIS ® is made by the Division of Medical Assistance (DMA).
- I understand that my ISP will be monitored and reviewed by my Care Coordinator, and that I can contact my Care Coordinator at any time if I have questions about my ISP, Individual Budget or the services that I receive.
- I understand that I have the right to choose a provider within (Insert name of PIHP) Provider Network.
- I understand that I am required to meet with my Care Coordinator for care coordination activities in the home or wherever my family member lives and/or all settings where services are provided to allow my Care Coordinator **access to all settings where services are provided**. The Care Coordinator will schedule meetings as often as needed in order to ensure appropriate service implementation and participant's needs are met. I may also request meetings.
- I understand that I am required to notify the Care Coordinator of any concerns regarding services provided.
- I understand that I am required to give adequate notice to the Care Coordinator of any change in address, phone number, insurance status, and/or financial situation prior to or immediately following the change.
- I understand that I am required to give adequate notice to the Care Coordinator of any behavior or medication changes as well as any change in health condition.

- I understand that I am required to attend appointments set by the Department of Social Services (DSS) to determine Medicaid renewals to ensure my continued Medicaid eligibility.
- I understand that I will be provided a copy of educational information about the NC Innovations waiver to assist with my understanding the services available through the NC Innovations waiver and guidelines that needs to be followed to ensure continued eligibility.
- I understand that (Insert name of PIHP) is responsible for ensuring an adequate network of provider agencies is available to promote choice for the participant.
- I understand that (Insert name of PIHP) will make a Care Coordinator available to provide care coordination supports which include:
 1. Assessment to determine service needs to include but not be limited to the, NC Innovations Risk/Support Needs Assessment.
 2. Working with the Individual Support Planning Team to coordinate and document the Individual Support Plan (ISP).
 3. Requesting all services that are determined necessary for the participant and listed in the ISP.
 4. Making the participants aware of the amount of their Individual Budget and the process used to establish this budget and make any needed changes.
 5. Monitoring all authorized services to ensure that they are provided as described in the ISP and that meet the participant's needs.
 6. Assisting the participant with the coordination of benefits through Medicaid and other sources to include, if needed, linkage with the local Department of Social Services regarding coordination of Medicaid deductibles.
 7. Responding to any complaints or concerns and reach resolution within 30 days of the complaint regarding NC Innovations services.
 8. Promoting the empowerment of the participant to lead as much of his/ her Individual Support Planning, decision making regarding the use of waiver dollars and oversight of waiver services as they choose.

9. Obtaining an order from the participant's physician for all needed medical supplies and specialized equipment.
10. Supporting the participant in obtaining all needed information to make an informed choice of provider within the (Insert name of PIHP) network, inclusive of notifying the (Insert name of PIHP) Network Management Department if providers are needed outside of the current (Insert name of PIHP) Network.

_____	_____
Name of Participant	Date

_____	_____
Signature of Participant (or Authorized Representative)	Date

PIHP

North Carolina Division of Mental Health, Developmental
Disabilities and Substance Abuse Services

Name: _____

Record Number: _____

Medicaid ID: _____

ISP Start Date: _____

Meeting Date: _____

Individual Support Plan For: _____**WHAT PEOPLE LIKE AND ADMIRE ABOUT ME...****WHAT'S IMPORTANT TO ME...****RELATIONSHIPS IN MY LIFE...****Natural, Unpaid, and Community Supports:****Paid Supports:**

WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME...
Life Situation
School/Vocational
Social Network
Medical/Behavioral

WHAT'S WORKING AND NEEDS TO STAY THE SAME OR BE ENHANCED...

WHAT'S NOT WORKING AND NEEDS TO CHANGE...

Crisis Prevention and Intervention**Significant Event(s) That May Cause Increased Stress / Trigger Crisis.**

(Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis Prevention and Early Intervention Strategies

(Describe what can be done to help this person AVOID a crisis. Include lessons learned from previous crisis events)

Strategies for Crisis Response and Stabilization

(Focus first on natural and community supports. Begin with least restrictive steps, include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable)

Systems Prevention and Intervention Protocols To Support The Individual

(i.e. who should be called and when, how can they be reached? Include contact names, phone numbers, etc. Be as specific as possible)

Designated Crisis Services Provider ☐ In-Home Skill Building provider ☐ Personal Care Provider
☐ Residential Supports provider
☐ Back-Up Staffing Agency for Individual/Family Directed Services

—

Employer of Record

Name of Agency: _____

Contact Person: _____

Day-Time Phone #: _____ After-hours Phone #: _____

Other

Specific Recommendations For Interacting With The Person Receiving a Crisis Service**Behavioral Supports Needed**

Behavior Support Plan is required if

- Rating is ≥ 13 for children (ages 21 and under)
- Rating is ≥ 10 for adults (ages 22 and over)
- Any individual identified as a Community Safety Risk based on self injury or dangerousness to others

Supports Intensity
Scale / Behavioral
Rating

Community Safety Risk
based on self injury or
dangerousness to
others?

☐ Yes
☐ No

Primary Care Physician

Name: _____

Phone: _____

Risk Summary		
Area of Support on Risk/Support Needs Assessment	Risk/Support Identified	
	Yes	No
Demographic Information	☒	☐
Material Supports	☐	☐
Physician Supports	☐	☐
Professional Supports	☐	☐
Medication Supports	☐	☐
Medical Treatment Supports	☐	☐
Health and Wellness Supports	☐	☐
Health Screenings /Preventative Care	☐	☐
Nutrition Supports	☐	☐
Vision Related Supports	☐	☐
Hearing Related Supports	☐	☐
Supports for Communicating Needs	☐	☐
Positive Behavior Supports	☐	☐
Safety Supports in Home and Community	☐	☐

All identified risks/supports must be included in/addressed within the plan.

Back-Up Staffing Plan		
Agency-Directed Services OR Individual/Family Direction / Agency With Choice (AWC) Model	who	Contact #
Agency Back-Up (mandatory)		
Non-Paid Back-Up (in the event of an emergency)		
Individual/Family Direction / Employer of Record (EOR) Model*	who	Contact #
Back-Up Staffing Agency (Back-Up Staffing Agency must be included, even if EOR does not anticipate needing to use this agency)		
* Employer of Record will ensure that Back-Up Staffing Plan for Individual/Family Directed Services is reviewed at least quarterly and that this review is documented.		

Action Plan

* For short-range goals, see provider plan

Long Range Outcome :			
Where am I now in Relationship to the Outcome? (Reason for outcome/Justification)			
Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date

* **Location Codes:** 1-Consumer's Home 2-Day Program 3-Residential Facility 4-Community 5-Place of Employment 6-Volunteer Site 7-Worker's Home 8-Other (Please specify)

Long Range Outcome :			
Where am I now in Relationship to the Outcome? (Reason for outcome/Justification)			
Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
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* **Location Codes:** 1-Consumer's Home 2-Day Program 3-Residential Facility 4-Community 5-Place of Employment 6-Volunteer Site 7-Community 8-Worker's Home 9-Other (Please specify)

Status of Individual and Family Direction	
N/A ☐	Individual is not an Innovations participant
Yes ☐ No ☐	Currently involved with Individual/Family Direction (If yes, skip the next 3 questions)
Yes ☐ No ☐	Orientation to Individual/Family Direction Given
Yes ☐ No ☐	Individual/Family Chose Not To Receive Orientation
Yes ☐ No ☐	Interested in Individual/Family Direction

Care Coordination
Your Care Coordinator can assist you in the following ways: • Assisting you with assessment and documentation of your support needs • Assistance with development of your plan and Individual Budget. • Monitoring services to ensure that you are receiving services to meet your needs and that you are happy with them. • Monitoring to ensure that you are healthy and safe. • Helping you receive information on directing your own services. • Help you with problems or complaints about services, if necessary.

Monitoring Plan (✓ all that apply)
☒ Minimum of monthly contact ☐ Minimum of monthly face-to-face contact Required for the following: • individuals living in residential placements, including alternative family living homes • individuals new to the waiver for the first six months • individuals who have service(s) provided by a guardian or relative living in the same home • individuals participating in Individual and Family Directed Services ☐ Minimum of quarterly face-to-face contact with individual ☐ Other

Issues To Be Resolved			
Issue	Discussion At Plan Meeting	Who needs to be involved?	Target Date

Signature Pages

Innovations Waiver / Level of Care Re-Determination	
☐	I certify that there has been no substantial change in the individual's condition and that the individual continues to require an ICF/MR Level of Care.
☐	There has been a change in the individual's condition and the individual needs an ICF/MR assessment.
Care Coordinator: _____	Date: _____

Innovations Waiver / Freedom of Choice	
I understand that enrollment in the Innovations Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded. I understand that in order to be determined to need waiver services, an individual must require the provision of <u>at least one waiver service monthly</u> and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.	
☐	I have chosen Innovations Waiver Services
☐	I have not chosen Innovations Waiver Services
_____ Signature of Individual or Legally Responsible Person	_____ Date

Statement of Concern or Disagreement

I, the individual/Legally Responsible Person signing this plan have concerns or disagree with the following issues related to my Individual Support Plan:

Plan Signatures

By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.

- My Care Coordinator helped me know what services are available.
- I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports.
- This plan includes the services/supports I need.
- I participated in the development of this plan
- I understand that the PIHP will be coordinating my care with the PIHP network providers listed in this plan.

Signature of Individual

Date

Signature of Legally Responsible Person

Date

Signature/Credentials of Care Coordinator

Date

Signature/Credentials of QP (if applicable)

Date

Other Signature

Date

Demographic Information

Name		Medicaid County	
Date of Birth		Other Insurance	
Address		Medicare #	
City, State, Zip		Insurance Carrier	
Phone #		Insurance #	
Current Living Situation	☐ Private Residence (residence rented/leased or owned by individual or family) ☐ Owned ☐ Rented/Leased ☐ Alternative Family Living/AFL Home (☐ Unlicensed , ☐ Licensed for __ beds) ☐ Non-Private Residence (residence leased or owned by provider) (☐ Unlicensed , ☐ Licensed for __ beds) ☐ Other (describe)		

Legally Responsible Person ☐ Self ☐ Parent (minor child) ☐ Legal Guardian
☐ Other (describe)

Name:	
Does the legally responsible person live in the home with person supported? ☐ Yes ☐ No (If no, provide address and phone # of legally responsible person below)	
Address:	
City, State, Zip:	
Phone:	

Participants in Plan Development

Name/Relationship	Name/Relationship

Assessments/Reports Utilized in Plan Development (mark all that apply)

☐ Supports Intensity Scale™	☐ Risk/Support Needs Assessment
☐ Assessment of Outcomes and Supports	☐ Other (describe)
☐ Other (describe)	☐ Other (describe)

Diagnostic Information

Axis	Code	Class	Description

Update to Individual Support Plan

Meeting Date: _____

Implementation Date: _____

**Based on what is happening in my life, what is important to me now?
What are my strengths and preferences?**

Based on what is happening in my life, what needs to change now?
(What new problems or needs do I have? What is not working in my life? What do others need to know or do to support me differently?)

Back-Up Staffing Plan		
Agency-Directed Services OR Individual/Family Direction / Agency With Choice (AWC) Model	who	Contact #
Agency Back-Up (mandatory)		
Non-Paid Back-Up (in the event of an emergency)		
Individual/Family Direction / Employer of Record (EOR) Model*	who	Contact #
Back-Up Staffing Agency (Back-Up Staffing Agency must be included, even if EOR does not anticipate needing to use this agency)		
* Employer of Record will ensure that Back-Up Staffing Plan for Individual/Family Directed Services is reviewed at least quarterly and that this review is documented.		

Action Plan

* For short-range goals, see provider

plan

Long Range Outcome:**Where am I now in Relationship to the Outcome?** (Reason for outcome/Justification)

Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
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* **Location Codes:** 1-Consumer's Home 2-Day Program 3-Residential Facility 4-Community 5-Place of Employment 6-Volunteer Site 7-Worker's Home 8-Other (Please specify)

Statement of Concern or Disagreement

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Update to ISP Signatures

By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.

- My Care Coordinator helped me know what services are available.
- I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports.
- This plan includes the services/supports I need.
- I participated in the development of this plan
- I understand the PIHP will be coordinating my care with the PIHP network providers listed in this plan.

Signature of Individual

Date

Signature of Legally Responsible Person

Date

Signature/Credentials of Care Coordinator

Date

Signature/Credentials of QP (if applicable)

Date

Other Signature

Date

Client:

Record Number:

Individual Budget

Effective Date: _____

Service Code:	Provider:	Qualifier:	Units Requested:	Rate:	Total	Start Date:	End Date:	Notes:	Discont Dat
					\$ -				
					\$ -				
					\$ -				
					\$ -				
					\$ -				

Innovations	Annual Budget:	\$ -						
Employer of Record Self Directed	Agency w/Choice Self Directed	Provider Directed	Equipment and Consultative Services	Base Budget Total			Add Ons	Total
\$	\$ -	\$ -	\$ -		\$ -		\$	\$ -

Funding Source Summary	Medicaid Waiver (c)	Medicaid State Plan	Other	Total
	\$ -	\$ -	\$ -	\$ -
			Total Budget:	\$ -

Individual Budget

Service Code:	Provider:	Units Req:	Period:	Start Date:	End Date:	Rate:

Individual Budget	Base Annual Budget:				
Participant-Directed (Self-Directed)	Agency Directed	Equipment	Unexpected Add Ons	Others	Total

Funding Source Summary	Medicaid	State	Other
	Total:		

Explanation of Individual Budget Fields

This is an annual budget that is inclusive of all authorized services/supports under the 1915c and 1915b waivers.

- Service Code – Identifies the Name of the Services and associated HCPCS or CPT code
- Qualifier – Identifies how the service is to be tracked in the Individual Budget (i.e., Provider Directed, Individual/Family Directed, Unexpected, Add On).
- Provider Name – Identifies the Provider of Service.
- Funding Source ID – Identifies the payer of service
- Units Requested – The frequency (number of service units requested)
- Start Date/End Date – The beginning and end date of requested Service
- Notes – Notes concerning the specific service
- Base Annual Budget – The total of the base budget
- Individual Family Directed – The total dollar amount of all authorized services that will be participant-directed
- Provider-Directed – The total dollar amount of all authorized services that will be Provider-Directed
- Add On's – The total dollar amount of authorized services from the Needs category of the Individual Budgeting Methodology.
- Equipment – The total of Equipment that is authorized
- Unexpected Needs –The total dollar amount of authorized services from the unexpected needs category of the Individual Budgeting Methodology.
- Total – Total of all waiver services authorized

Innovations Waiver / Freedom of Choice

I understand that enrollment in the NC Innovations Waiver is strictly voluntary. I also understand that if I am determined to be ICF-MR eligible, I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded (ICF-MR). I understand that in order to be determined to need waiver services, an individual must require the provision of at least one waiver service monthly and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.

☐ I **have chosen** NC Innovations Waiver Services

☐ I **have not chosen** NC Innovations Waiver Services

Signature of Individual or Legally Responsible Person

Date

Out of State Travel Request Form

Date of Request: _____
Name of Individual: _____
Dates of Travel: From: _____ To: _____
Destination: _____

1. Natural Supports Traveling with Individual (include relationship to individual):

2. Individual's Daily Needs:

3. Staff Requirements (based on needs above):

4. Why are natural supports unable to meet individual's needs:

5. What services need to be delivered out of state (must be habilitative service):

On what schedule will these services be delivered:

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- If licensed professionals are involved, Medicaid cannot waiver other state licensure laws
- Medicaid will not be responsible for room, board, or transportation cost
- Provider Agencies, Employers of Record or Agencies With Choice must assume all liability for their staff while out of state
- Individual Support Plans must not be changed to increase services while out of state
- Respite, based on the definition, is not available as natural supports are present during the travel or are not available to individuals receiving Residential Supports.

By signing below, the provider agency agrees with this request and to all above listed conditions:

Agency Supervisor Signature: _____ Date: _____

Agency With Choice Signature: _____ Date: _____

Managing Employer Signature: _____ Date: _____

Send form to:
(PIHP Contact/Address)

PIHP use only:

☐ Approved

☐ Denied

Comments:

Reviewer Signature

Date

Client: _____ Record Number: _____

NC Innovations Risk/Support Needs AssessmentCompleted by: _____ Date Assessment Completed: _____
Name/Position

Input Obtained From	
☐	Participant
☐	Family / Friends (List name/relationship)
☐	Support Workers (List name/relationship)
☐	Other (List name/relationship)

Purpose of Assessment

- o Identify **supports** necessary to successfully participate in essential activities of life
- o Identify significant **risks** regarding the individual's health/safety and the safety of others.
- o Inform team of supports and/or risks that need to be addressed.
- o Assist support team to ensure a balance between what is 'important TO' the participant and what is 'important FOR' the participant

Instructions

- 1) This assessment must be completed within 90 calendar days prior to planning meeting and when there are significant changes in the participant's life.
- 2) The assessment must be completed with input from the participant/legally responsible person and other members of the support team.
- 3) The participant's preferences, needed supports and strategies to address identified risks must be included in the plan.

A. Demographic Information		
Current Living Situation	☐ Private Residence (residence leased or owned by participant or family) ☐ Alone ☐ With Family ☐ With Others/ Describe:	Residence is ☐ Owned ☐ Rented/Leased
	☐ Non-Private Residence ≤6 beds (residence leased or owned by provider) ☐ Alone ☐ Residential Facility (licensed for ___ beds)	
	☐ Alternative Family Living (AFL) ☐ Unlicensed/1 bed ☐ Licensed for ___ beds	
	☐ Congregate Living > 6 Beds or ICF-MR Facility ☐ Nursing Facility ☐ Developmental Center ☐ Group Home (non ICF-MR) >6 beds ☐ Adult Care Home ☐ Community ICF-MR	Is residence/living situation expected to change? ☐ Yes ☐ No If yes, describe:
Education	☐ Attends school Where?	☐ Home Schooled (must have certificate to support)
	☐ Homebound Reason:	☐ N/A (☐ < Age 3 ☐ > age 21 ☐ completed school)
	☐ Other (Describe)	
Is a relative or guardian living with adult participant a paid caregiver?		☐ Yes ☐ No ☐ N/A (child) If yes, list Relationship and Service Provided
Current MH/DD/SA Services (include service and provider)		

B. Material Supports (mark all that are in place now)	
☐ Personal Lift	☐ PERS Unit (Personal Emergency Response System)
☐ Bedrails	☐ Telecommunication display (TDD)
☐ Wheelchair ☐ Manual ☐ Power	☐ Walker
☐ Walker	☐ Orthopedic Braces
☐ Vehicle Modifications (Describe)	☐ Augmentative Communication (Describe)
☐ Home Modifications (Describe)	☐ Environmental controls (Describe)
☐ Medical Devices (e.g., pacemaker, C-PAP machine, glucometer, seizure management device, prosthetic device, etc. Does not include glasses, contacts, or hearing aids). Describe:	

☐	Other – Describe
Needed Material Supports (needed vehicle or home modifications, assistive technology/devices, etc that are not in place at this time)	
Describe:	

C. Physician Supports				
√	Profession	Name/Clinic	Recommended Frequency of Visits (e.g. monthly, quarterly, annually, as needed)	Approximate Date of Last Visit
☐	Primary Care Physician			
☐	Psychiatrist			
☐	Neurologist			
☐	Orthopedist			
☐	Dentist			
☐	Other (Identify Profession)			
☐	Other (Identify Profession)			

D. Professional Supports				
√	Profession	Name/Clinic	Recommended Frequency of Visits (e.g. 1x/week, 2x/week, monthly, quarterly, annually, as needed)	Approximate Date of Last Visit
☐	Registered Nurse			
☐	Licensed Practical Nurse			
☐	Physical Therapist			
☐	Occupational Therapist			

☐	Speech Language Pathologist			
☐	Psychologist			
☐	Counselor			
☐	Other (Describe)			
☐	Other (Describe)			

E. Medication Supports				
Name of Medication	What Is It For?	Dosage / Frequency	How Is It Taken? (method of administration – oral, injection, suppository, etc)	To Be Given By (self, family, staff, etc)

Allergies, Interactions and Adverse Reactions:

F. Medical Treatment Supports (e.g. catheterization, tube feeding, dressing changes, suctioning, oxygen, splints, braces, etc.)				
Treatment	What Is It For?	Frequency	How Is It Performed?	To Be Given By (self, family, staff, etc)

G. Health and Wellness Supports		
Yes	No	
☐	☐	Requires support to manage a <u>medical or health condition</u> (ex. Seizures, Diabetes, Sleep Apnea, Narcolepsy, life-threatening allergy, etc.) Describe:
☐	☐	Requires support to promote <u>skin integrity</u> (e.g. has pressure sore or history of pressure sores, incontinent with cognitive impairment) Describe:
☐	☐	Requires support to promote <u>oral hygiene/health</u> .

H. Health Screening/Preventative Care	
☒	(select all that have been received)
☐	Height/Weight Measurement
☐	Cancer breast/testicular exam
☐	Mammography – Women
☐	Pap Smear – Women
☐	Prostate cancer screening – Men
☐	Hypertension screening
☐	Cholesterol screening
☐	Diabetes Type II screening
☐	Preventative Dental Care
☐	Other Health Screenings/Preventative Care Describe:

I. Nutrition Supports		
Yes	No	
☐	☐	1. Food/Liquid Consistency - Requires food or liquid to be in particular consistency or size (e.g. chopped into specific pieces, ground up, pureed, thickened, etc). Describe:
☐	☐	2. Medically Prescribed Diet Requires medically prescribed diet (e.g. diabetic, low salt, high/low calorie, nutritional supplement, etc.) Describe: Does participant/caregiver understand the dietary restriction/follow?
☐	☐	Requires support due to history or risk of dehydration.
☐	☐	Requires support due to history or risk of choking (swallowing risk factors include coughing during or after meals, excessive throat clearing during or after meals, or gagging on food or liquids).

J. Vision Related Supports (select only one)	
☐	No support needed to see well
☐	Requires corrective lenses to see well Does participant have and wear corrective lenses? ☐ Yes ☐ No
☐	Requires large print and/or other modification even with corrective lenses Are needed modifications provided? ☐ Yes ☐ No
☐	Requires support to participate in activities requiring vision even with corrective lenses
K. Hearing Related Supports (select one only)	
☐	No support needed to hear speech
☐	Requires prosthesis/hearing aid(s) to hear well Does participant have and wear prosthesis? ☐ Yes ☐ No
☐	Requires environmental modification (e.g., increased volume, special seating), lip reading or some use of alternative communication (e.g., writing, pointing) even with prosthesis Describe: Are needed environmental modifications provided? ☐ Yes ☐ No
☐	Does not hear well enough to understand most or all speech, even with prosthesis

L. Supports for Communicating Needs (select one only)	
☐	None; can communicate most or all essential needs
☐	Requires extra time or technology to communicate essential needs.
☐	Requires full assistance from familiar persons to communicate many essential needs
☐	Requires full assistance from familiar persons to communicate most or all essential needs
How does the participant communicate best? (e.g. speaking, gesturing, communication board, sign language, behaving in certain ways, etc):	
Non-Verbal Ways the Participant Communicates	
When Participant Does This	We Think It Means This

M. Positive Behavior Support		
Yes	No	
☐	☐	Requires support to learn about and/or avoid actions that endanger self or others (e.g., crossing the street safely) or due to lack of action (e.g., no response to fire, will allow others to victimize).
☐	☐	Requires support to participate in school, work and/or recreation within established rules (e.g., refuses rules, refuses direction, disrupts or unaware of rules or social norms).
☐	☐	Requires support to participate in desired activities because of difficulties with anger control, anxiety, depression, substance abuse or other mental health concerns .
☐	☐	Requires support to prevent, manage or provide therapy for behaviors or conditions that can potentially cause physical harm to self or others or that may be a misdemeanor (e.g., aggression, self-injury, property destruction, extreme food or liquid seeking, pica, running away, window peeping, stripping in public, shoplifting, sleep disturbance)
☐	☐	Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are expected to cause serious harm to self or others if not addressed or that may be a felony (e.g., aggression or self-injury causing bleeding or broken bones, fire setting behavior, sexual behavior with a minor or incompetent/unconsenting adult, felony theft, felony possession of drugs, dealing drugs).
☐	☐	Requires a highly structured environment with specially trained staff to prevent or manage behaviors that are imminently life threatening (e.g., suicidal, homicidal, sexual assaults).
Notes (if applicable):		

N. Safety Supports in Home and Community		
Yes	No	
☐	☐	Has stairs within home and requires hands on assistance or close supervision to use stairs.
☐	☐	Requires support to regulate water temperature.
☐	☐	Requires close supervision due to risk of wandering away.
☐	☐	Requires support due to inability to make safe choices when at home (e.g. not putting metal in microwave or toaster, not opening door to strangers, etc).
☐	☐	Requires support due to inability to make safe choices when in the community (e.g. crossing street safely, refusing ride from a stranger, etc.).
☐	☐	Requires support to evacuate home in event of fire.
☐	☐	Requires support because home is not accessible to meet needs. Describe:
☐	☐	Requires support because he/she is unable to avoid being taken advantage of financially (e.g. not giving his/her money to strangers, not giving out personal financial information to strangers, etc.)
☐	☐	Requires support or assistance because of other safety concerns within the home or community that could put the person at risk (unsanitary/unsafe housing, unsafe neighborhood, caregiver stress, service refusal/interfering, social isolation, etc). Describe:
Does this person require 24 hour supervision to ensure safety? ☐ Yes ☐ No If “no”, how many hours at one time can this person typically be safely left • alone in the house or residence, <u>with no other adults at home</u>? _____ Hours. • alone in the community or other setting away from the home? _____ Hours. If precautions need to be taken to ensure safety when left alone, describe:		
Does this person require someone to be awake at night to ensure health/safety? ☐ Yes ☐ No If yes, please explain (e.g. Why is awake supervision required at night? Why are environmental modifications not adequate to ensure the person’s health and safety?)		

Risk Summary

Area of Support	Risk / Support Identified?		Comments (if applicable)
	Yes	No	
Demographic Information	☐	☐	
Material Supports	☐	☐	
Physician Supports	☐	☐	
Professional Supports	☐	☐	
Medication Supports	☐	☐	
Medical Treatment Supports	☐	☐	
Health and Wellness Supports	☐	☐	
Health Screenings /Preventative Care	☐	☐	
Nutrition Supports	☐	☐	
Vision Related Supports	☐	☐	
Hearing Related Supports	☐	☐	
Supports for Communicating Needs	☐	☐	
Positive Behavior Supports	☐	☐	
Safety Supports in Home and Community	☐	☐	

Minimum Elements for Innovations ISP Approval**General Demographics****Participant Name****Care Coordinator Name****Date-Stamped in or written in****Initial**

Required Documents/Assessments
Supports Intensity Scale (or NC SNAP)
Risk/Support Needs Assessment
NC Innovations Level of Care and supplemental medical if appropriate
Behavior Plan, if applicable
Other supporting documentation as needed for example: IEP, IFSP, vocational assessments, Home School certificate and schedule, equipment documentation...
Individual Family Supports documentation
Freedom of Choice document
ISP
Effective date of ISP is the latest of 3 dates: Medicaid application date (SIPPS) Level of Care effective date Date of Deinstitutionalization
ISP Services Content
The Back-Up Staffing Plan is indicated.
The Action plan is completed with long range outcomes.
Long Range Outcomes support the need for the requested service(s).
For new waiver participants (those not grandfathered upon admission to NC Innovations when the PIHP joins the waiver), the participant lives in a private residence, or lives in a facility no larger than 6 beds.
The use of the requested service is consistent with the service definition, the service exclusions and other requirements in the <u>NC Innovations Technical Guide</u> .
The requested service(s) is not covered under the State Medicaid Plan.
For participants ages 3-21, the requested service is not covered by the public school system, public school extended school year, private school, home school, or home bound school arrangement, including related transportation services unless the participant has completed school at age 18.
The requested service is not covered by Vocational Rehabilitation, including related transportation services.
Individual services are clinically indicated.
Group services are authorized if no individual services are clinically indicated.
Location of service
Individual Budget
Effective date is documented.
Services listed match the Action Plan.
Service Code and Qualifier are correct.
Units calculated match Action Plan.
Provider listed matches Action Plan.
Rate is correct for service (standard rate or client specific).
Budget calculations are correct.

Services do not exceed the NC Innovations Waiver Limits on Sets of Services .
Service specific limits are met.
Total waiver budget including base and add on services does not exceed \$135,000.

Health and Welfare
Services and supports in the ISP reflect participant's assessed risk factors (Risks documented on the Risk Support Needs Assessment match the ISP).
Level of appropriate staff and staff supervision is addressed.
Behavior Supports, if restrictive, have the appropriate approval and monitoring.
Issues to be resolved addresses needs that are indentified in the ISP.
Signature Page
Authorized individual chose the NC Innovations Waiver.
ISP signature section is signed by the authorized individual if the waiver participant is adjudicated incompetent.
Level of Care
Participant determined to be ICF-MR eligible.
LOC process is followed.
LOC form is used.
Signed by an MD, Licensed Psychologist or Psychologist Associate
LOC was authorized within 30 days of signature of the professional.

Annual Plan

Required Documents/Assessments
Supports Intensity Scale (or NC SNAP)
Risk/Support Needs Assessment
Behavior Plan, if applicable
Other supporting documentation as needed for example: IEP, IFSP, vocational assessments, Home School certificate and schedule, equipment documentation...
Individual Family Supports documentation
ISP Services Content
The Back-Up Staffing Plan is indicated.
The Action plan is completed with long range outcomes.
Long Range Outcomes support the need for the requested service(s).
For existing waiver participants (those not grandfathered upon admission to NC Innovations when the PIHP joins the waiver), the participant lives in a private residence, or lives in a facility no larger than 6 beds.
The use of the requested service is consistent with the service definition, the service exclusions and other requirements in the <u>NC Innovations Technical Guide</u> .
The requested service(s) is not covered under the State Medicaid Plan.
For participants ages 3-21, the requested service is not covered by the public school system, public school extended school year, private school, home school, or home bound school arrangement, including related transportation services unless the participant has completed school at age 18.
The requested service is not covered by Vocational Rehabilitation, including related transportation services.
Individual services are clinically indicated.
Group services are authorized if no individual services are clinically indicated. * appeals

Location of service
Individual Budget
Effective date is documented.
Services listed match the Action Plan.
Service Code and Qualifier are correct.
Units calculated match Action Plan.
Provider listed matches Action Plan.
Rate is correct for service (standard rate or client specific).
Budget calculations are correct.
Services do not exceed the NC Innovations Waiver Limits on Sets of Services.
Service specific limits are met.
Total waiver budget including base and add on services does not exceed \$135,000.
Health and Welfare
Services and supports in the ISP reflect participant's assessed risk factors (Risks documented on the Risk Support Needs Assessment match the ISP).
Level of appropriate staff and staff supervision is addressed.
Behavior Supports, if restrictive have the appropriate approval and monitoring.
Issues to be resolved addresses needs that are identified in the ISP.
Signature Page
Authorized individual chose the NC Innovations waiver.
ISP signature section is signed by the authorized individual if the waiver participant is adjudicated incompetent
Continues to meet ICF-MR level of care

ISP Update

Required Documents/Assessments
Supports Intensity Scale (or NC SNAP) if applicable based on change requested
Risk/Support Needs Assessment if applicable based on change requested
Behavior Plan, if applicable on change requested
Other supporting documentation as needed for example: IEP, IFSP, vocational assessments, Home School certificate and schedule, equipment documentation...
Individual Family Supports documentation
ISP Services Content
The Back-Up Staffing Plan is indicated.
The Action plan is completed with long range outcomes
Long Range Outcomes support the need for the requested service(s).
For existing waiver participants (those not grandfathered upon admission to NC Innovations when the PIHP joins the waiver), the participant lives in a private residence, or lives in a facility no larger than 6 beds.
The use of the requested service is consistent with the service definition, the service exclusions and other requirements in the <u>NC Innovations Technical Guide</u> .
The requested service(s) is not covered under the State Medicaid Plan.
For participants ages 3-21, the requested service is not covered by the public school system, public school extended school year, private school, home school, or home bound school arrangement, including related transportation services unless the participant has completed school at age 18.
The requested service is not covered by Vocational Rehabilitation, including related transportation services.
Individual services are clinically indicated.

Group services are authorized if no individual services are clinically indicated. *appeals
Location of service
Individual Budget
Effective date is documented.
Services listed match the Action Plan.
Service Code and Qualifier are correct.
Units calculated match Action Plan.
Provider listed matches Action Plan.
Rate is correct for service (standard rate or client specific).
Budget calculations are correct.
Services do not exceed the NC Innovations Waiver Limits on Sets of Services.
Service specific limits are met.
Total waiver budget, including base and add on services does not exceed \$135,000.

Health and Welfare
Services and supports in the ISP reflect participant's assessed risk factors (Risks documented on the Risk Support Needs Assessment match the ISP).
Level of appropriate staff and staff supervision is addressed.
Behavior Supports, if restrictive have the appropriate approval and monitoring.
Issues to be resolved addresses needs that are identified in the ISP.
Signature Page
ISP signature section is signed by the authorized individual if the waiver participant is adjudicated incompetent

Equipment Modifications and Supplies (Assistive Technology Equipment and Supplies; Home Modifications, Vehicle Adaptations)

Generally Required for All
The ISP includes a training and technical assistance plan detailing the purpose and use of the equipment/supply/modification for the participant, caregiver, and/or family.
Shipping costs are included as long as they are itemized in the request.
When a written recommendation is required by an appropriate professional and a physician's signature to certifying medical necessity, the PIHP determines if the physician's signature must be included on the recommendation or if it may be on a separate document per the PIHP policy.
When a written recommendation is required by an appropriate professional and a physician's signature to certifying medical necessity, the PIHP determines if the physician's signature must be included on the recommendation or if it may be on a separate document per the PIHP policy.
The PIHP determines the appropriate professional(s) that make written recommendations for services that require those recommendation
When quotes are required for purchases, the PIHP policy determines how many quotes are required.
Only one device and any disability specific accessories necessary for operation will be approved to meet the need addressed by the equipment/supply/modification unless more than one device is medically necessary.
The equipment/supply/modification is not a restrictive device as defined under North Carolina Client Rights Rules.
There is a recommendation from a physician, physical therapist, occupational therapist, speech therapist, or vocational rehabilitation/automobile adaptive equipment specialist.

The equipment/supply/modification does not address a need that can be met by equipment or supplies on the State Medicaid Plan.
Items that are denied as not medically necessary under any other plan are not covered by the waiver.
Replacement of equipment/supply/modification is not covered if the item is damaged because of carelessness or abuse or failure to maintain insurance coverage.
All exclusions and limits apply for Assistive Technology Equipment and Supplies, Vehicle Modifications and Home Modifications.

Assistive Technology Equipment and Supplies-specific criteria

An assessment/recommendation by an appropriate professional that identifies the participant's need(s) with regard to the Equipment and Supplies being requested. The assessment/recommendation must state the amount of an item that a participant needs.
Supplies that continue to be needed at the time of the participant's Annual Plan must be recommended by an annual re-assessment by an appropriate professional. The assessment/recommendation must be updated if the amount of the item the participant needs changes.

Requests for Adaptive Car Seats require the following:

- o Individuals must have a documented chronic health condition of developmental disability which requires the use of an adaptive car seat for positioning. Car seats will not be approved for behavioral restraint.
- o Individuals must have a documented chronic health condition of developmental disability which requires the use of an adaptive car seat for positioning. Car seats will not be approved for behavioral restraint.

Prior approval must be requested with the following information in the assessment:

- o Participant's weight
- o Weight limits of the car seat currently used to transport
- o Participant has a seat to crown height that is longer than the back height of the largest child car safety seat if the participant weighs less than the upper weight limit of the current car seat. The measurements must be documented.
- o Reasons why the participant cannot be safely transported in a car seat belt or convertible or booster seat for individual weighing 30 pounds and up.
- o Certification of medical necessity, assessment requirements and price quotes required by PIHP policy and NC Innovations Technical Guide
- o Positioning chairs are not covered if the participant has mobility/positioning system.
- o Reusable undergarments are only covered for participants over the age of two.
- o Nutritional supplements are covered by mouth only and only if they are included on the State Home Infusion Therapy List. Pudding or other pre-thickened food and juice are not covered. Prescription deeming "medical necessity" is required.

For Home Modifications, the following additional information is required:

Assessment/recommendation by an appropriate professional that identifies the participant's need with regard to Home Modifications requested.

For Vehicle Adaptations, the following additional information is required:

The recommendation must contain information regarding the rationale for the selected modification, pre-driving assessment if the participant will be driving the vehicle, condition of the vehicle to be modified, and insurance on the vehicle to be modified. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles and the family.

If purchasing a used vehicle with a lift on it, the price of the used lift on the used vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the participant/family may not take possession of the lift prior to approval by the PIHP Utilization Management Department.
Evaluation by an adapted vehicle supplier with an emphasis on safety and “life expectancy” of the vehicle in relationship to the modifications.
If paying for labor and costs of moving devices/equipment from one vehicle to another vehicle, then training on the use of the device is not required.
A recommendation by a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation.

Other Services

Community Transition Services
Only one transition will be funded for the Participant in a lifetime
The Community Transition checklist is required
Individual Goods and Services
The purchase is not payment for room, board, bills, credit card payments or other similar debts.
The purchase or services is not alcohol or tobacco products, firearms, contraband or illegal items or services.
The purchase is not a payment for court-ordered costs, fines, restitution, attorney fees, or other similar debts or services.
The service does not include conference housing and meals.
The service has not been paid for by the family member
Habilitation and Support Services
The requested service(s) are not provided as a substitute for childcare for children ages 11 and under unless specialized services are required because of the child’s disability.
Community Networking Services
The service location is in the community and does not originate from a licensed day program.
The requested service does not duplicate services that are the responsibility of the Residential Supports provider.
Crisis Services
The service is authorized to meet an acute crisis situation and is not authorized to meet needs requiring daily on-going support.
The service is authorized to meet an acute crisis situation that requires face-to-face intervention.
In Home Intensive Support
Request for In Home Intensive Support has been approved by the Medical Director /Assistant Medical Director

**Individual Family Directed Supports
Assessments/ Required Forms**

Correct assessment for Individual Family Direction • Employer of Record • Agency with Choice
Representative Needs Assessment is complete and present, if applicable.
Representative Designation Agreement, if applicable
Documentation of training for participant, representative, if applicable
Representative is requested or has been mandated by PIHP, if applicable
Community Guide is requested or has been mandated by PIHP, if applicable
If employer is not the participant there is a plan documented in the ISP to involve the participant.
The Employer is 18 years of age.
The Employer has not been excluded from Medicaid and has no pending fraud investigation.
Employer's needs identified in assessment and agreement is supported in the ISP.
Employer cannot be the paid staff person.

NC Innovations Waiver Limits on Sets of Services

Participant Age/Status	Living in Residential Setting, including AFL	Living in Private Home
Adult	No more than 40 hours per week any combination: • Community Networking • Day Supports <i>and/or</i> • Supported Employment Services May receive up to one daily unit of Residential Supports	No more than 84 hours/week any combination: • Community Networking • Day Supports • Supported Employment • In-Home Skill Building <i>and/or</i> • Personal Care
Child during school year (Ages 0 to 17 unless 18 and older and enrolled in school)	No more than 20 hours per week any combination: • Community Networking • Day Supports <i>and/or</i> • Supported Employment Services May receive up to one daily unit of Residential Supports	No more than 54 hours/week any combination: • Community Networking • Day Supports • Supported Employment • In-Home Skill Building <i>and/or</i> • Personal Care
Child when school is not in session (Ages 0 to 17 unless 18 and older and enrolled in school)	No more than 40 hours per week of any combination: • Community Networking • Day Supports <i>and/or</i> • Employment Services May receive up to one daily unit of Residential Supports	No more than 84 hours/week of any combination: • Community Networking • Day Supports • Supported Employment • In-Home Skill Building <i>and/or</i> • Personal Care

Services Not Subject to Limits on Sets of Services

Additional Services contained in the Individual Budget	• Community Guide Services	• Community Guide Services • Respite
Additional Services: Add On to Individual Budget	• Assistive Technology Equipment/Supplies • Community Transition Services • Crisis Services • Natural Supports Education • Specialized Consultative Services	• Assistive Technology Equipment/Supplies • Crisis Services • Home Modifications • Natural Supports Education • Specialized Consultative Services • Vehicle Modifications
Available to Participants Who Self-Direct service(s)	• Individual Goods and Services	• Individual Goods and Services

Note: An adult or child with intensive support needs may receive Daily Residential Supports in 1 of 5 levels, based on the intensity of support needs.

An adult or child living in a private home may receive up to 12 hours/day of In-Home Intensive Support

Care Coordination Standard Monitoring Form

MONITORING ACTIVITIES CHECKLIST FOR: GENERAL MONITORING		
PROVIDER:	INDIVIDUAL:	DATE:
Minimum responsibility for general monitoring is to be alert for these items, discuss with provider QP as applicable to confirm that all requirements are met, follow-up further as indicated.		
** Employer of Record/EOR only if model has been implemented within MCO		Check/Comments
Client Rights	Approved/Planned Restrictive Intervention (if applicable): Provider/EOR ** must have signed consent from individual/LRP to conduct an approved intervention unless unplanned. The need for the approved intervention must be written into the Individual's ISP and Positive Behavior Support Plan. If restrictive interventions are included in the PBSP, it must be signed/approved by a licensed psychologist. Provider's Client Rights Committee (MCO CRC for EOR**) must review and approve/disapprove use of planned restrictive intervention (APSM 95-2, NCAC 10A)	
	Protective Devices (if applicable): Provider/EOR** must have signed consent from individual/LRP to use Protective Devices for support. Use of Protective Devices must also be approved by the provider's Client Rights Committee. Protective Devices include but are not limited to seizure helmets, wheelchairs, AFOs, standers, etc.	
	Devices to Modify Behaviors are Prescribed and in ISP: If individual requires devices to modify behaviors, there is a physician's order to support it filed in record and the use of device is included in ISP and PBSP as outlined above for Restrictive Intervention.	
	Rights Restrictions: If the individual's rights are restricted, Provider QP must assess need and reason for restriction and place written statement in record detailing need for restriction. Effective date cannot exceed 30 days - the right must be restored or the restriction renewed each 30 days, with restoration or renewal documented in provider record. Provider QP must assess restriction every 7 days, documenting this review in record. Individual/LRP must be notified when rights restriction is implemented and at each renewal (NC G.S. 122C - 62)	
Health/Safety	Self-Administering Medication: Provider has physician's order for individual to self-administer medications and there is documentation that individual has received medication education prior to self-administering each new medications. (Not required in private homes)	
	Medication Closet Locked? Residential Facilities and licensed Day Programs are required to keep Medication closet/cabinet/boxes locked when not in use. (Not required in private homes)	
	Incidents - Be alert in discussions with providers and/or individuals/families - consider how issues were resolved, if treatment was provided if needed, if patterns are identified, etc.	
	Health & Safety Checklist/Justification for Personal Care/Respite Provided in the Direct Service Employee's Home: Confirm with QP that Health/Safety Checklist requirements have been addressed if the individual receives Personal Care or Respite in the home of the worker. Confirm with QP that no other service is being delivered in worker's home.	

Appendix N-- CC Monitoring Form

North Carolina Innovations Waiver

Facility	Facility is Well Maintained: Always be alert for and address any potential health and safety risks (e.g. wiring/plumbing problems, tripping risks etc). Serious and/or ongoing issues must be reported to QM.	
	Confidentiality is Respected: Follow-up on any concerns regarding confidentiality (e.g. staff calling person's first/last name while in public, individual's name posted on wall with medications, etc). Personal Health Info. (i.e.. diet restrictions, toileting schedule, allergies, medications, etc...) should not posted in facility.	
	Facility License is Current: If you become aware that a licensed facility or a facility that should be licensed is NOT licensed, this must be reported to QM..	
	Adequate Supplies on Hand? If there is indication that required supplies are not available (e.g. materials needed to run goals, adequate food supply, etc), follow-up on this with provider and report to QM as indicated.	

MONITORING ACTIVITIES CHECKLIST FOR: PROVIDER REVIEW		
PROVIDER:	INDIVIDUAL:	DATE:
Provider Review		Check/Comments
Service Documentation (On-Site)	Short Range Goals (Present, Include All Required Elements, Target Dates Current): Provider must have short range goals that link back to long range outcomes in the ISP and a copy of these goals must be accessible to the direct support staff member on-site. Check to make sure that dates on goals have not expired. Provider may not bill for running expired or achieved goals. Short Range Goal (s) must be in place BEFORE the service (ANY service) is delivered. Short range goal elements include measurable goal statement; strategies, interventions or task analysis to meet the goal; target date including month/day/year; signature of LRP.	
	Positive Behavior Support Plan (as applicable): Copy of current PBSP is accessible to direct care staff and documentation supports that PBSP is being followed. There should be behavioral data documented.	
	Service Notes/Service Grid completed per service requirement for each service: Service Grid is allowed only for Day Supports, IHSB, Personal Care, Residential Supports, Respite, Supported Employment and Community Networking and requires: name of individual receiving service, Medicaid ID#, month/day/year of service, goal addressed, number or letter as specified in appropriate key which reflects the intervention/activities/tasks performed, number or letter as specified in the appropriate key which reflects the assessment of progress toward goal, duration, initials of individual providing service, corresponding full signature in signature log section of grid. Service Notes are used for all other services and require: name of individual receiving service, Medicaid ID#, Name of Service, month/day/year of service, purpose of service (tied to specific short-range goal), description of intervention/support provided, duration, effectiveness of the intervention, full signature and degree or position/title.	
	Service Notes/Service Grid Match the Short Range Goals and Documented Interventions/Task Analysis/Strategies: Review on-site service documentation/data to see if service note/service grid reflect data being properly documented. Service Grids should have a Key that reflects type of criteria/data to be documented. Crosswalk goals to Service Grids and Task Analysis/Strategy to see if they match. Reminder: Medicaid # is to be on all Provider Documentation.	
	Services Delivered As Outlined in Plan: Review service documentation available on-site (i.e. notes or grid) to determine if documentation supports that services are being delivered as outlined in plan. If service deviations have occurred, ensure that the reason for deviation is documented.	

Appendix N-- CC Monitoring Form

North Carolina Innovations Waiver

	Medication Administration Records (required for Residential and Day Programs if meds are administered/not required in private homes) Documentation includes medication, times dispensed, refusals and errors, etc... How were med. errors and refusals handled for health and safety of the individual? It is clear why the individual is taking all of the medications prescribed. If not for the usual diagnosis, inquire as to what other medical reason is medication taken?	
	Other Documentation (as applicable): Review other applicable service documentation such as seizure logs, sleep logs, etc. Some providers (particularly facility-based services such as Residential, Day Supports) keep seizure logs, sleep data or other documentation specific to the individual.	
	Always be alert for client rights, facility requirements, etc. See "General Monitoring" sheet for items that should be monitored on an ongoing basis by all Care Coordinators.	
Provider Review		Check/Comments
Service Observation with Individual and Provider	Observe Goals Being Run: Watch the individual with their trainer/staff to verify service delivery and to see if short range goal was run according to the Task Analysis/Intervention/Strategy and if short range goal relates to a long range outcome in the ISP. Back-Up employees should be able to follow the training steps easily. Look for consistency.	
	Individual Vs. Group: If the service being observed is supposed to be Individual, make sure that this is what is occurring. A person can receive individualized assistance (e.g. toileting, ambulation, eating, etc...) even if the service authorized is for group. A person authorized to receive individual service should not be receiving services in a group setting (including care of other family members, etc...). The individual service worker should have responsibility for only the one individual.	
	Staff Demonstrate Skill to Support/Train Individual per ISP: Observe Direct Care staff to see if it appears they have been trained on the specific needs of the individual per ISP and on the TAs/Strategies to run goals. Does staff have supplies necessary to run the goals? If you have questions, ask the QP about person's qualifications and discuss need for training or retraining.	
	Individual Encouraged to Exercise Rights: Observe Direct Care staff to see if they encourage person to exercise their rights or if there is a violation of rights.	
	Staff Demonstrate Respect & Ensure Privacy: Watch to see that individual has the right to privacy or if their privacy is being violated.	
	Equipment Use and Care: Verify that approved equipment has been delivered, that individual and staff have been trained on use and care of equipment; equipment is being used in all environments; equipment is in good working order and there is a schedule for cleaning and maintenance as necessary. Equipment may include but is not limited to: wheelchairs/other mobility items, leg braces, communication devices, positioning devices, aids for daily living, home or vehicle modifications.	
Provider Contact	Review w/ QP: Review and discuss individual's progress/status with provider QP (e.g. progress on goals, service deviations if applicable, changes in medical status, concerns, needed changes to plan, incidents that have occurred, etc).	

Appendix N-- CC Monitoring Form

North Carolina Innovations Waiver

	Medical Appointments/Follow-Up: All appts attended/rescheduled? Were Dr's orders followed? All team members are aware of the new orders, symptoms, side effects, etc...? Age appropriate health checks/exam/tests performed? Are new consents needed to obtain medical records?	
	Discuss w/ QP Commendations & Follow-up Plan for Concerns: Praise for a job well done and address any questions, concerns, changes needed in service delivery including but not limited to service documentation, record keeping, medical/health issues, facility issues, Client Rights, staff training needs, etc... Follow procedure on Monitoring of Provider Service re: time lines and reporting issues to QM.	
	Progress Summary - During contact with QP, progress should be discussed. Care Coordinator can request copy of quarterly Progress Summary as needed.	
Claims Review	Claims Review: Reviewing claims submitted by the provider helps you monitor to ensure that the individual is receiving services as outlined in the plan and/or to identify potential service deviations. Remember that absence of billing does not necessarily indicate that the service was not provided. Any potential service deviations identified via review of claims require follow-up/further research to identify if a service deviation occurred and, if so, the reason for the deviation. Based on reasons for deviation, additional follow-up may be indicated (e.g. updating plan if individual's needs have changed).	

MONITORING ACTIVITIES CHECKLIST FOR: CONTACT WITH INDIVIDUAL/LEGALLY RESPONSIBLE PERSON		
INDIVIDUAL:	LRP:	DATE:
Review Items		Check/Comments
Services / Outcomes and Supports	Satisfaction with services and progress: Is individual/LRP satisfied with services, providers, care coordination, etc...? Ask each separately. Offer to help resolve issues.	
	Satisfaction with Treatment Progress? Inquire about moving toward progress on their personal and hab goals. Who supports them? Who else needs to support them? What needs to change? What needs to stay the same?	
	Are services being delivered as outlined in ISP? Are any changes to plan needed? Discuss with individual/family to ensure that services are being delivered as per plan and to identify any needed changes. If services deviations are occurring by individual/family choice (e.g. picking individual up early on regular basis, telling IHSB worker not to come, etc), educate them about importance of following plan.	
	Community Guide Needs? Be alert for need for Community Guide services (e.g. need for advocacy, help accessing Medicaid transportation resources, accessing medical care, identifying/accessing other community supports, etc). Never perform functions that are the role of Community Guide - instead assist the person in accessing Community Guide services. If already receiving Community Guide services, be alert for new identified needs which may require a new Long Range Outcome in plan.	
	Verify Supplies and Equipment Receipt and Use: Inquire if ongoing supplies are being delivered regularly. Verify if approved equipment has been delivered, that individual or family has been trained on use and care of equipment, equipment is being used in all environments i.e. community, home and school/work/day program and equipment is in good working order?	
	Documentation to Support Appointment of Legally Authorized Representative or Advanced Directive: If individual has a legally appointed representative (e.g. guardian, power of attorney) OR has a Advanced Directive (e.g. Advanced Directive for Psychiatric Care, Living Will), obtain copy for record.	
	Concerns About Capacity to Make Decisions? Is the Individual an Adult or Soon to be 18? If so and there is not a legally authorized representative, are there concerns about the individual's capacity to make independent decisions? If there are concerns, discuss with individual/family Alternatives to Guardianship and Guardianship.	

	Orientation to Individual/Family Direction (Self-Direction- For Innovations Consumers Only): Offer/Present and document that you have informed the individual of the 2 models of Self-Direction under Innovations: Employer of Record (EOR) and Agency With Choice (AWC). Review "NC Innovations Individual & Family Directed Supports Information Booklet" and provide a copy. (EOR only applicable if model has been implemented within MCO)	
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MONITORING ACTIVITIES CHECKLIST FOR: INNOVATIONS - SELF-DIRECTION - AGENCY WITH CHOICE (AWC)		
INDIVIDUAL:	MANAGING EMPLOYER:	AWC PROVIDER:
Review Items w/ Managing Employer in Addition to the Provider Review		Check/Comments
Required: Managing Employer was involved with the selection of current staff?		
Required: Monthly Review w/ Managing Employer & AWC Required: CC to monitor self-directed services monthly. Check to see if each service is being utilized as authorized. Review documentation of training/supervision completed by Managing Employer if applicable. Review if others such as natural supports (next door neighbor/other relatives, etc...) drop by to observe services provided by the AWC. Managing Employer has all necessary employment supplies if applicable.		
Required: Satisfaction with Services and Progress. Is family satisfied with services, progress, self-direction processes, training, PIHP and AWC? Any concerns or suggestions? Offer to help resolve issues.		
Required: Quarterly Financial Report Reviewed by CC, Managing Employer and AWC: CC reviews quarterly financial report produced by the Agency w/ Choice with Managing Employer. Follow up with AWC on any questions about the report that are not clear.		
Optional: Medically Necessary Services Meet Needs, Health & Safety. Issues to consider: identified needs of the individual are being addressed, schedule of services is flexible, individual is involved w/ community, individual budget is sufficient for needs.		
Optional: Back-Up Staffing Plans in Place, Being Tested & Problems Noted: Back-up staffing plan is practiced quarterly. Issues to consider: frequency of employees failing to report to work, use of back-up employees, need for different employees.		
Optional: Service Documentation and Timesheets for AWC: Managing Employer is reviewing and signing off on documentation and timesheets of direct care staff from AWC if applicable.		
Optional: Confidentiality/Record Keeping. Documentation kept in home is in secure location if applicable.		

Note: Monthly face-to face monitoring is required. Every month, for the 1st six (6), at least one of the self-directed services must be observed as the service is being delivered. Monthly contact must be maintained with the Managing Employer and/or Representative.

****REFER TO SEPARATE MONITORING CHECKLIST FOR EMPLOYER OF RECORD (EOR) (applicable only if model has been implemented within MCO)**

****THIS CHECKLIST IS TO BE DONE IN ADDITION TO THE CHECKLIST FOR PROVIDER REVIEW.**

**NC Innovations Waiver
Referral Form from CAP-MR/DD to NC Innovations**

Today's Date: _____

Individual's Name: _____

Current Medicaid County: _____

Medicaid Number: _____

Effective Date of Medicaid change as verified by DSS: _____

Individual's Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone () _____

Alternate Number () _____

Legally Responsible Person/Guardian: _____

Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone () _____

Alternate Number () _____

NC County that the Individual is requesting transfer to: _____

Address once transferred: _____

LME that the individual is requesting transfer from: _____

LME contact: _____

LME contact Phone number: () _____

CAP-MR/DD Case Management Agency: _____

CAP-MR/DD Case Management Contact Person: _____

Contact Phone number: () _____

Residential Setting and Size of Facility:

Current Residence: (Circle one) HOME GROUP HOME- # of Beds _____
AFL- # of Beds _____

Current Day Service: (Circle one) SCHOOL EMPLOYMENT NONE

The following documentation is required:

- ✓ An approved current CAP-MR/DD Plan of Care
- ✓ Risk Assessment
- ✓ Supports Intensity Scale/NCSNAP
- ✓ An approved MR- 2

- ✓ A current psychological evaluation inclusive of adaptive behavior, if available, copies of any evaluations relevant to the person's care
- ✓ An IEP or Vocational Rehabilitation Letter, if available
- ✓ CAP-MR/DD current approval form
- ✓ The current approved Cost Summary
- ✓ Copies of current guardianship or legal custody documentation
- ✓ Copies of releases

Send to referral packet to: LME Representative

By signing this form, I acknowledge that I will need to participate in the completion of a new Level of Care and the development of a new Plan of Care once funding is identified for me.

Signature of LME Representative

Date

Signature of Case Management Representative

Date

Signature of Legally Responsible
Person(s)

Date

Signature of Legally Responsible
Person(s)

Date

**NC Innovations Waiver
Referral Form from NC Innovations Waiver to CAP-MR/DD**

Today's Date: _____

Individual's Name: _____

Current Medicaid County: _____

Medicaid Number: _____

Effective Date of Medicaid change as verified by DSS: _____

Individual's Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone () _____

Alternate Number () _____

Legally Responsible Person/Guardian: _____

Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone: () _____

Alternate Number: () _____

Support Coordinator: _____

Support Coordinator Contact Information:

Address: _____

Telephone Number: () _____

NC County that the Individual is requesting transfer to: _____

LME that the individual is requesting transfer to: _____

Current Provider Agency(ies) and each service the person is receiving:

The following documentation is required:

- ✓ Current approval form for ISP
- ✓ An approved current Individual Support Plan
- ✓ Risk Support Needs Assessment
- ✓ Supports Intensity Scale
- ✓ An approved Level of Care or original Level of Care and current re-determination
- ✓ A current psychological evaluation inclusive of adaptive behavior, if available, copies of any evaluations relevant to the person's care
- ✓ An IEP or Vocational Rehabilitation Letter, if available
- ✓ The current approved Individual Budget
- ✓ Copies of current guardianship or legal custody documentation
- ✓ Copies of releases to the new LME

Send to referral packet to: LME Representative

By signing this form, I acknowledge that I will need to participate in the completion of a new Level of Care and the development of a new Plan of Care once funding is identified for me.

Signature CCD Care Coordinator

Date

Signature of CCD LUC

Date

Signature of Legally Responsible
Person(s)

Date

Signature of Legally Responsible
Person(s)

Date

**NC Innovations Waiver
Referral Form from NC Innovations Waiver PIHP to NC Innovations PIHP**

Today's Date: _____

Individual's Name: _____

Current Medicaid County: _____

Medicaid Number: _____

Effective Date of Medicaid change as verified by DSS: _____

Individual's Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone () _____

Alternate Number () _____

Legally Responsible Person/Guardian: _____

Street Address: _____

City: _____

State: _____ Zip code: _____

Telephone: () _____

Alternate Number: () _____

Care Coordinator: _____

Care Coordinator Contact Information:

Address: _____

Telephone Number: () _____

NC County that the Individual is requesting transfer to: _____

PIHP that the individual is requesting transfer to: _____

Current Provider Agency(ies) and each service the person is receiving:

The following documentation is required:

- ✓ Current approval form for ISP
- ✓ An approved current Individual Support Plan
- ✓ Risk Support Needs Assessment
- ✓ Supports Intensity Scale or NC SNAP
- ✓ An approved Level of Care or original Level of Care and current re-determination
- ✓ A current psychological evaluation inclusive of adaptive behavior, if available, copies of any evaluations relevant to the person's care
- ✓ An IEP or Vocational Rehabilitation Letter, if available
- ✓ The current approved Individual Budget
- ✓ Copies of current guardianship or legal custody documentation
- ✓ Copies of releases to the new PIHP

Send to referral packet to: PIHP Representative

Signature Care Coordinator

Date

Signature of PIHP NC Innovations Waiver Manager

Date

Signature of Legally Responsible Person(s)

Date

Signature of Legally Responsible Person(s)

Date

**VERIFICATION OF
RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE**

This document is to be completed by PIHP Network Provider Agency or Employers of Record as a part of their certification of compliance with the Innovations Relative/Legal Guardian as Provider Policy

Please note that parents, biological or adoptive, and step-parents cannot be employed to provide services to their minor children (under 18 years of age) under the Innovations waiver.

Part A Application – New Employees

Please complete one application per prospective “new” employee. Part A applies to employees that are being newly interviewed. Use Part B for employees that were employed by your agency prior to the implementation of the Innovations Waiver Relative as Direct Support Employee Policy or have been previously certified through this process.

Section I

Date of Submission: _____

Participant Name: _____ Participant's Age at Time of Application: ____

Date of Birth: ____/____/____ **Note: This process applies to waiver participants who are 18 years of age or older**
dd / mm / yyyy

Waiver Region that Participant's Medicaid originates from: _____

Name of Provider Agency **QP** or Employer of Record: _____

Agency Name: _____

Address: _____

Phone Number(s): _____

Prospective Employee (Name): _____

Relationship to Consumer: ☐Mother ☐Father ☐Other: _____

Legal Guardian ☐ Yes ☐ No

Does this Relative or Legal Guardian live in the same home as the waiver participant?

☐Yes ☐No **If no, then this request is not applicable for review**

List only up to 40 total hours per week.
 Requests for hours greater than 40 hours per week must be submitted on a Part C Application.
 (only the additional hours above 40 are recorded on Part C).

Section II

Which service (s) will be provided:

- ☐ Community Networking - How many hours requested _____ per week **or** _____ per day
- ☐ Day Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Personal Care - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Individual) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Group) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Intensive Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Residential Supports - How many units per week _____

Will the Relative or Legal Guardian be providing: ☐ primary **or** ☐ back up services?

Who will provide required Back-up Staffing? _____

If the person is the legal guardian what strategies is the Provider Agency going to employ to ensure that the decisions made by the employee are in the best interest of the waiver participant?

Section III

PIHP must prior authorize the provision of services by a family member or legal guardian living in the same household as the waiver participant.

**As Provider Agency or Employer of Record, I am verifying the following:
 (Please check each item verified and provide additional justification if requested.)**

1. **The relative or legal guardian must meet the provider qualifications for the service. Response to a) is required. Response to b) and c) as appropriate to the individual's needs.**
 - a) ☐ The prospective employee (relative or legal guardian) meets the provider qualifications for the specific service they are being interviewed/employed to provide. (To be verified by QM upon on-site review.)
 - b) ☐ If **medical tasks** are required to meet the individual's needs, the employee only performs tasks they are qualified to provide under the NC Nursing Practice Act. Please detail the tasks:

 - c) ☐ The provider certifies that there is documented training for the specific medical task by a professional appropriately qualified in the task or equipment and that the employee receives nursing supervision to carry out this function as specified by the NC Nursing Practice Act.
2. **A qualified provider who is not a relative or legal guardian is:**
 - a) ☐ Not available to provide the service. Please describe why:

Number of people interviewed and not hired for the position and the justification for not hiring each staff person

Total number interviewed: _____

Justification: (Please check all that apply and attach additional sheets if necessary)

- ☐ Did not have necessary skills (# interviewed: _____)
- ☐ Not available at the days/times/places necessary (# interviewed: _____)

- ☐ Difficulty with interpersonal relationships; please explain: (# interviewed: ____)

- ☐ Staff not available due to remote location; please explain: (# interviewed ____)

- ☐ Other; please explain: (# interviewed ____)

OR

- b) ☐ A qualified provider is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the family member or legal guardian. Please explain: (e.g. specialized nursing training, holds a license in a field required for the service etc.)

3. ☐ The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.

4. ☐ The prospective employee is not the:

- Employer of Record or Managing Employer in an Agency with Choice model
- Respite Service provider
- The spouse of the waiver participant

Section IV

What is the intended work schedule of the prospective employee?: Hours per day/days of the week, etc.

NOTE: If the intended work schedule is more than 40hrs per week, you must complete a Part C Application.

Is there staff currently assigned to deliver services to the waiver participant? If so, how many and what hours do they work?

What is the plan to introduce additional staff to provide some of the services that are needed by the waiver participant?

Section V – Signatures

- ☐ The prospective employee understands that the Provider Agency/Employer of Record will monitor the service that a relative or legal guardian provides each month on-site, at a minimum of one time per month.
- ☐ The prospective employee understands that the PIHP Support Coordinator will monitor the relative/legal guardian's provision of services on-site, at a minimum of one time per month.
- ☐ The prospective employee will provide Community Networking, Day supports, Personal Care, In-Home Skill Building (Individual), In-Home Skill Building (Group), In-Home Intensive Supports, and/or Residential Supports. Payments are only made for service authorized by the PIHP Utilization Management Department in the Individual Support Plan.

Signature below certifies that I/we have received and read PIHP's Innovations Waiver Employment of Relative/Legally Responsible Person Policy and that all information on the form is true and accurate. Falsification of this information could result in a Medicaid payback. The employee understands that communications regarding this submission should be directed to their Employer of Record or Provider Agency.

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Print Name)

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Signature, Title and Date)

Employee Providing Service Signature, Relationship and Date

NOTE: If this form is incomplete it will be denied. Only original documents will be accepted (no copies, faxes or emails please).

Optional Comments: _____

Forward Information to: _____ (Address of PIHP)

Date received: _____

VERIFICATION OF RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE

This document is to be completed by PIHP Network Provider Agency as a part of their certification of compliance with the Innovations Relative/Legal Guardian as Provider Policy

Please note that parents, biological or adoptive, and step-parents cannot be employed to provide services to their minor children (under 18 years of age) under the Innovations waiver.

Part B Application – Existing Employees

Please complete one application per “existing” employee. Part B applies to employees that were employed by your agency prior to the implementation of the Innovations Waiver Relative as Direct Support Employee or have been previously certified through this process. Use Part A for “newly” interviewed employees.

Section I

Date of Submission: _____

Participant Name: _____ Participant's Age at Time of Application: _____

Date of Birth: / / **Note: This process applies to waiver participants who are 18 years of age or older**
dd / mm / yyyy

Waiver Region that Participant's Medicaid originates from: _____

Name of Provider Agency **QP** or Employer of Record: _____

Agency Name: _____

Address: _____

Phone Number(s): _____

Prospective Employee (Name): _____

Relationship to Consumer: ☐ Mother ☐ Father ☐ Other: _____

Legal Guardian ☐ Yes ☐ No

Does this Relative or legal guardian live in the same home as the waiver participant?

☐ Yes ☐ No **If no, then this request is not applicable for review**

List only up to 40 total hours per week.
Requests for hours greater than 40 hours per week must be submitted on a Part C Application
(only the additional hours above 40 are recorded on Part C).

Section II

Which service (s) will be provided:

- ☐ Community Networking - How many hours requested _____ per week **or** _____ per day
- ☐ Day Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Personal Care - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Individual) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Group) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Intensive Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Residential Supports - How many units per week _____

Will the relative or legal guardian be providing ☐ primary or ☐ back up services?

Who will provide required Back-up Staffing? _____

If the person is the legal guardian what strategies is the Provider Agency going to employ to ensure that the decisions made by the employee are in the best interest of the waiver participant?:

_____**Section III****PIHP must prior authorize the provision of services by the family member or legal guardian living in the same household as the waiver participant.****As Provider Agency or Employer of Record, I am verifying the following:
(Please check each item verified and provide additional justification if requested.)****5. The relative or legal guardian must meet the provider qualifications for the service. Response to a) is required. Response to b) and c) as appropriate to the individual's needs.**

- a) ☐ The prospective employee (relative or legal guardian) meets the provider qualifications for the specific service they are being interviewed/employed to provide. (To be verified by QM upon on-site review.)
- b) ☐ If **medical tasks** are required to meet the individual's needs, the employee only performs tasks they are qualified to provide under the NC Nursing Practice Act. Please detail the tasks:

- c) ☐ The provider certifies that there is documented training for the specific medical task by a professional appropriately qualified in the task or equipment and that the employee receives nursing supervision to carry out this function as specified by the NC Nursing Practice Act.

6. A qualified provider who is not a relative or legal guardian is:

- a)
- ☐
- Not available to provide the service. Please answer the following:

Year and month that the relative/legal guardian was hired by your agency: _____

Did the relative/legal guardian work for another provider agency prior to employment with your agency?

☐ Yes ☐ No. If yes, which agency? _____Does your agency employ other staff to provide services to this waiver participant? ☐ Yes ☐ No

If yes, what other services? _____

OR

- b) ☐ A qualified provider is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the family member or legal guardian. Please explain: (e.g. specialized nursing training, holds a license in a field required for the service etc.)

7. ☐ The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.

8. ☐ The prospective employee is not the:

- Employer of Record or Managing Employer in an Agency with Choice model
- Respite Service provider
- The spouse of the waiver participant

Section VI

What is the intended work schedule of the prospective employee? _____

NOTE: If the intended work schedule is more than 40hrs per week, you must complete a Part C Application.

Is there staff currently assigned to deliver services to the waiver participant? If so, how many and what hours do they work? _____

What is the plan to introduce additional staff to provide some of the services that are needed by the waiver participant? _____

Section V – Signatures

- ☐ The prospective employee understands that the Provider Agency/Employer of Record will monitor the service that a relative or legal guardian provides each month on-site, at a minimum of one time per month.
- ☐ The prospective employee understands that the PIHP Support Coordinator will monitor the relative/legal guardian's provision of services on-site, at a minimum of one time per month.
- ☐ The prospective employee will provide Community Networking, Day supports, Personal Care, In-Home Skill Building (Individual), In-Home Skill Building (Group), In-Home Intensive Supports, and/or Residential Supports. Payments are only made for service authorized by the PIHP Utilization Management Department in the Individual Support Plan.

Signature below certifies that I/we have received and read PIHP's Innovations Waiver Employment of Relative/Legally Responsible Person Policy and that all information on the form is true and accurate. Falsification of this information could result in a Medicaid payback. The employee understands that communications regarding this submission should be directed to their Employer of Record or Provider Agency.

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Print Name)

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Signature, Title and Date)

Employee Providing Service Signature, Relationship and Date

NOTE: If this form is incomplete it will be denied. Only original documents will be accepted (no copies, faxes or emails please).

Optional Comments: _____

Forward Information to: (Address of PIHP)

Date received: _____

**VERIFICATION OF
RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE**

This document is to be completed by PIHP Network Provider Agency as a part of their certification of compliance with the Innovations Relative/Legal Guardian as Provider Policy

**Part C Application
Request to Exceed 40 Hours**

Date of submission: _____

Participant Name: _____

Name of Provider Agency QP or Employer of Record: _____

Agency Name: _____

Address: _____

Phone Number(s): _____

Prospective Employee: _____

Ordinarily, no more than 40 hours per week or seven daily units per week may be approved for service provision between all family members who reside in the same household as the waiver participant. Additional service hours furnished by a family member or legal guardian who resides in the same household as the waiver participant may be authorized to the extent that another provider is not available or it is necessary to assure the participant's health and welfare.

☐ This employee meets the basic employment guides under the Relative/Legal Guardian as Provider Process.

Please specify below, the additional hours being requested (beyond the 40 hours that are indicated on your **Part A or Part B Application**):

- ☐ Community Networking - How many hours requested _____ per week **or** _____ per day
- ☐ Day Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Personal Care - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Individual) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Skill Building (Group) - How many hours requested _____ per week **or** _____ per day
- ☐ In-Home Intensive Supports - How many hours requested _____ per week **or** _____ per day
- ☐ Residential Supports - How many units per week _____

Proposed effective date: _____

What is the total amount respite authorized for this waiver participant? _____

Who provides the respite? _____

Justification for requested hours: (attach additional sheets if necessary)

Signature below certifies that I/we have received and read PIHP's Innovations Waiver Employment or Relative/Legally responsible Person policy and that all information on the form is true and accurate. Falsification of this information could result in a Medicaid payback.

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Print Name)

Provider Agency Qualified Professional, Employers of Record, Managing Employers
(Signature, Title and Date)

Employee Providing Service Signature, Relationship and Date

Forward Original Application and Justification Documents to: (Address of PIHP)

Date received: _____

VERIFICATION OF RELATIVE/LEGAL GUARDIAN AS DIRECT SUPPORT EMPLOYEE

This document is to be completed by the Network Provider Agency/Agency with Choice/Employer of Record as a part of their certification of compliance with the Innovations Relative/Legal Guardian as Provider Policy

Please note that parents, biological or adoptive, and step-parents cannot be employed to provide services to their minor children under the Innovations waiver. This process only applies to waiver participants who are 18 years of age or older

Part D Application – Request for Reinstatement

The Part D Application applies to employees that have had their previous Relative/Legal Guardian as Direct Support Employee approval discontinued for cause. Please complete one application per employee for whom this process is applicable.

Section I

Date of Submission: _____

Name of Provider Agency **QP** or Employer of Record: _____

Agency Name: _____

Address: _____

Phone Number(s): _____

Name of Employee Reinstatement is being requested for: _____

Relationship to Consumer: ☐ Mother ☐ Father ☐ Other: _____

Legal Guardian? ☐ Yes ☐ No

Does this Relative or Legal Guardian live in the same home as the waiver participant?

☐ Yes ☐ No, **If no then this process is not applicable for review**

Date previous approval was discontinued for cause: ____/____/____

Reason for discontinuation of previous approval (Attach additional pages if necessary):

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Who will provide required Back-up Staffing? _____

If the person is the legal guardian what strategies is the Provider Agency/Agency with Choice/Employer of Record going to employ to ensure that the decisions made by the employee are in the best interest of the waiver participant?

Section III (All items in the section must be addressed)

PIHP must prior authorize the provision of services by a family member or legal guardian living in the same household as the waiver participant.

**As Provider Agency or Employer of Record, I am verifying the following:
(Please check each item verified and provide additional justification if requested.)**

9. The relative or legal guardian must meet the provider qualifications for the service. Response to a) is required. Response to b) and c) as appropriate to the individual's needs.

- a) ☐ The prospective employee (relative or legal guardian) meets the provider qualifications for the specific service they are being interviewed/employed to provide. (To be verified by QM upon on-site review.)
- b) ☐ If **medical tasks** are required to meet the individual's needs, the employee only performs tasks they are qualified to provide under the NC Nursing Practice Act. Please detail the tasks:
-
- c) ☐ The provider certifies that there is documented training for the specific medical task by a professional appropriately qualified in the task or equipment and that the employee receives nursing supervision to carry out this function as specified by the NC Nursing Practice Act.

10. A qualified provider who is not a relative or legal guardian is:

- a) ☐ Not available to provide the service. Please describe:

Number of people interviewed and not hired for the position and the justification for not hiring each staff person

Total number interviewed: _____

Justification: (Please check all that apply and attach additional sheets if necessary)

- ☐ Did not have necessary skills (# interviewed: _____)
- ☐ Not available at the days/times/places necessary (# interviewed: _____)
- ☐ Difficulty with interpersonal relationships; please explain: (# interviewed: _____)

☐ Staff not available due to remote location; please explain: (# interviewed ____)

☐ Other; please explain: (# interviewed ____)

OR

b) ☐ A qualified provider is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the family member or legal guardian. Please explain: (e.g. specialized nursing training, holds a license in a field required for the service etc.)

11. ☐ The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.

12. ☐ The prospective employee is not the:

- Employer of Record or Managing Employer in an Agency with Choice model
- Respite Service provider
- The spouse of the waiver participant

Section VI

What is the intended work schedule of the prospective employee?: Hours per day/days of the week etc. _____

NOTE: If the intended work schedule is more than 40hrs per week please fill out the Part C Application and submit it with this form.

Is there staff currently assigned to deliver services to the waiver participant? If so, how many and what hours do they work?

What is the plan to introduce additional staff to provide some of the services that are needed by the waiver participant?

Section V – Signatures

- ☐ The prospective employee understands that the Provider Agency/Agency with Choice/Employer of Record will monitor the service that a relative or legal guardian provides each month on-site, at a minimum of one time per month.
- ☐ The prospective employee understands that the PIHP's Support Coordinator will monitor the relative/legal guardian's provision of services on-site, at a minimum of one time per month.
- ☐ The prospective employee will provide Community Networking, Day supports, Personal Care, In-Home Skill Building (Individual), In-Home Skill Building (Group), In-Home Intensive Supports, and/or Residential Supports. Payments are only made for service authorized by the Utilization Management Department in the Individual Support Plan.
- ☐ If reinstatement is granted, the approval shall be conditional for a period of ninety (90) days or less. Quality Management will monitor the services and documentation provided by the Relative or Guardian under this policy during the conditional approval period.
- ☐ If reinstatement is granted, failure to resolve all issues that lead to the previous discontinuation within the conditional approval period will result in revocation of the reinstatement.
- ☐ Revocation of the reinstatement or any future discontinuation of approval for cause under this process will result in permanent discontinuation of this parent or guardians approval under the Relative/Guardian as Direct Support Employee. The Revocation of reinstatement and permanent discontinuation decisions by PIHP are not appealable.

Signature below certifies that I/we have received and read PIHP's Innovations waiver Employment of Relative/Legally Responsible Person policy and that all information on the form is true and accurate. Falsification of this information could result in a Medicaid payback. The employee understands that communications regarding this submission should be directed to their Employer of Record or Provider Agency.

Employee Providing Service Signature, Relationship and Date

Provider Agency Qualified Professional, Employers of Record, Managing Employers
PRINT NAME, Signature, Title and Date

- ☐ If reinstatement is granted, the Provider Agency/Agency with Choice/Employer of Record understands they are at full risk for the payback of Medicaid funds associated with services provided by the Relative/Guardian if the Plan of Correction/Training, Supervision, and Monitoring plan is not implemented or followed, the requirements under Medicaid service definition are not met, and/or appropriate and required documentation is not completed.

Provider Agency/Agency with Choice CEO or Manager with Authority to make financial decisions

PRINT NAME, Signature, Title and Date

Optional Comments:

NOTE: If this form is incomplete it will be denied. Only original documents will be accepted (no copies, faxes or emails please).

Forward Information to: _____ (Address of PIHP)

Date received: _____

Health and Safety Checklist

Name of Direct Service Employee _____
 Location of Service Address _____
 City, State, Zip Code _____
 Telephone Number at Service Location _____

Assurance	Met	Not Met	Comments
1. The home is free from any hazards that present a risk to the Participant's health and safety. Appropriate safety preventive devices are in place to include at a minimum of a smoke detector on each level of the home.			
2. Medications, hazardous cleaning supplies, or firearms in the home are kept in a secure (locked) location.			
3. Pets that the Participant comes in contact with have up-to-date vaccinations. If the pet presents a risk to the safety of the Participant, the pet must be kept in a secure location, separate from the portions of the home accessed by the Participant.			
4. There is an evacuation plan specific to the Participant in the home, and it is tested at least monthly.			
5. If the Participant requires adaptive equipment for services and supports provided in the employee's home, that equipment must be available. Medicaid does not fund duplicate equipment for the purpose of availability in the employee's home.			
6. A criminal background check is performed for any adult who lives in the home, who is present during the time the Participant is receiving services. The results of the background check do not present any safety risk for the Participant.			
7. A healthcare registry check is performed for any adult who lives in the home, and who is present during the time the Participant is receiving services. The results of the healthcare registry check do not present any safety risk for the Participant.			

- ✓ The Provider Agency verifies that this information is accurate and has been discussed with the Direct Service Employee providing Personal Care or Respite in their own home. This checklist is valid for this location only.
- ✓ Services provided are documented in the Individual Support Plan with the Direct Service Employee's home listed as the service location.
- ✓ Services provided in the direct service employee's home do not include In-Home Skill Building or In-Home Intensive Supports.
- ✓ Services provided at this location are based on the documented needs of the Participant, not for the convenience of the employee.
- ✓ The Individual Support Plan states how the Participant's needs are better met in the direct service employee's home.

Appendix Q – Health and Safety Checklist Justification North Carolina Innovations Waiver

- ✓ Personal Care/Respite are not billed when the direct service employee is providing direct care to another child or person. If the direct service employee is providing direct care to another child or person, the Participant's health and safety must be assured.
- ✓ The Participant may not clean or perform other household tasks in the direct service employee's home, including preparing meals for the direct service employee's family.
- ✓ Medication administration regulations are followed for any medications that the Participant is assisted in taking.
- ✓ If the Participant has a goal to learn to evacuate the Participant's private home, that goal must be trained in the Participant's home.
- ✓ The Participant and/or Participant's guardian/family may not be charged for any damage to the Direct Service's Employee's property or any additional charge for the service provided. The issue of liability insurance to cover accidents to/by the Participant is addressed by the Provider Agency.
- ✓ The NC Innovations Waiver does not pay for room and board costs.
- ✓ The Care Coordinator has access to the service location during hours that services are provided to the Participant for both announced and unannounced monitoring visits.
- ✓ The Provider Agency will make and document at least one monthly site visit during hours of service provision to make sure that the services provided are consistent with the Individual Support Plan, and that the environment continues to be healthy and safe for the Participant.
- ✓ The Provider Agency agrees to immediately notify the Participant's Care Coordinator if there is any situation that involves the health and safety of the Participant in the Direct Service Employee's home, including providing the Care Coordinator with a copy of any Incident Report. Other Incident Reporting requirements per the Provider Agency's contract with the MCO must also be followed.

Signature of Provider Agency
Representative/Date

Signature of Direct Service
Employee/Date

Signature of Provider Agency Administrator/Date

Signature of Participant/Legally
Responsible Person/Date

Original Maintained in Agency or Employer Participant File

Individual and Family Directed Supports Assessment Employer of Record Model

Individual _____ Record Number _____

Person Assessed _____
(Employer)

Person Assessed _____
(Proposed Representative)

	Yes	No
Are you at least 18 years old?		
Have you ever been convicted of Medicaid or Medicare fraud or excluded from participating in the Medicaid or Medicare Program?		
Do you plan to use Community Guide Services?		
Are you willing to name a Representative or use Community Guide Services, if you are assessed to need one or both?		

Assessment Date: ____/____/20__ Care Coordinator: _____	
What services are you planning to self-direct?	
What are your plans for ensuring back-up staffing for employees?	
What are your plans for keeping information confidential in the individual's home?	

	Assessment Assistance needed?	
	Yes	No
Has copies of all manuals and forms related to the Individual/Family Directed Supports Model selected, and knows how to obtain additional forms and updates; knows how to access the Innovations Web Site		
Understands the differences between services that are Individual/Family Directed and those that are provider directed		

	Assessment Assistance needed?	
	Yes	No
Knows the difference between Employer of Record and Agency With Choice Models of Individual/Family Directed Supports		
Understands that a Representative may be appointed at any time, the role of a representative, and the process for appointing a representative		
Understands how the individual and Individual/Family Budgets work, including what is included in each part of the budget, and how to request additional funding in the Individual and Family Directed Supports Budget		
Knows how to complete the Financial Support Service Agreement and when and how to update it		
Knows how to contact the Community Guide and the Financial Support Services Agency		
Understands employer taxes		
Understands insurance (worker's compensation and liability)		
Understands and able to comply with labor laws that apply to the model selected		
Understands staff qualifications for each service definition and the individual specific staff qualifications		
Knows how to write a job description and establish employee guidelines		
Understands how and where to recruit employees, including how to request that a newspaper ad be run		
Able to interview and request background checks for potential employees		
Knows how to request the auto calculator, use the auto-calculator and how to set employee pay rates and benefits		
Has a process for developing Employee Support Service Agreements, including developing the Employee's Supervision Plan		
Understands and able to comply with labor laws that apply to the model selected		
Understands staff qualifications for each service definition and the individual specific staff qualifications		
Knows how to write a job description and establish employee guidelines		
Understands how and where to recruit employees, including how to request that a newspaper ad be run		
Able to interview and request background checks for potential employees		
Knows how to use the auto-calculator and how to set employee pay rates and benefits		
Has a process for developing Employee Support Service Agreements, including developing the Employee's Supervision Plan		

	Assessment Assistance needed?	
	Yes	No
Has resources for employee training and knows the process for obtaining training paid by the Financial Support Service Agency; has a plan or training protocols for any training that the Employer is providing		
Understands how to address problems with employees, including documenting those actions, including firing employees etc.		
Understands how to discharge an employee, including all required documentation needed by the Financial Support Service Agency		
Knows how to work with the Employee Security Commission should a former employee file an unemployment claim, including claims filed should the Employer of Record decide to stop participating in the Employer of Record Model		
Has a plan for back-up staffing and has selected a Crisis Services provider if self-directing Home Supports		
Understands confidentiality requirements for both individual and employee documentation and has established methods for meeting those requirements		
Understands how to write/revise short term goals and strategies for those goals based on long range outcomes in the Individual Support Plan		
Knows what is billable Medicaid time versus non-billable time		
Has developed emergency protocols, has a plan for testing them, and has a plan for documenting those tests		
Understands the purpose, use, and cost of Community Guide Services		
Understands that the Individual Support Plan must be followed (service frequency and duration) and that changes to it must be requested through the Care Coordinator, including how to request additional Community Guide Services		
Knows how to review the Financial Support Services Monthly Reports, including how to work with the Financial Support Service Agency should there be problems with the Report		
Understands the requirements of the documentation of services		
Understands that the Employer may choose to terminate Individual/Family Directed Supports or transfer to a different Model at any time and also understands that specific processes must be followed		
All Community Guide outcomes/short-range goals regarding start-up of Individual and Family Directed Supports are met		

Assessment of Support:

√ all that apply	The Employer of Record or Representative, if applicable
	Is requesting the add on Community Guide to assist with initial training and support
	Is not requesting the add on Community Guide to assist with initial training and support
	Has indicated intention not to request Community Guide Services beyond the initial 30 training hours currently included in the ISP
	Understands that a Community Guide Agency must be selected for obtaining required materials and forms and abide by procedures of that Agency for obtaining those materials/forms. Only one Agency may be used at any one point in time and must be noted in the ISP. The Agency will provide no other services beyond providing the materials/forms, if a decision has been made not to use Community Guide services.

Signatures:

Care Coordinator

Date

Person Assessed

Date

Pre-Assessment

cc:

Utilization Management Department (with ISP/Update requesting self-directed service, EOR model)

Individual Medical Record

Employer of Record and Representative, if applicable

Community Guide

Individual and Family Directed Supports Assessment Agency With Choice Model

Individual _____ Record Number _____

Person Assessed _____ (Employer)

Person Assessed _____ (Proposed
Representative)

Assessment Date: ____/____/20__ Care Coordinator: _____	
What services are you planning to self-direct?	

	Yes	No
Are you at least 18 years old?		
Have you ever been convicted of Medicaid or Medicare fraud or excluded from participating in the Medicaid or Medicare Program?		
Do you plan to use Community Guide Services?		
Are you willing to name a Representative or use Community Guide Services, if you are assessed to need one or both?		

	Assessment Assistance needed?	
	Yes	No
Has copies of all manuals and forms related to the Individual/Family Directed Supports Model selected, and knows how to obtain additional forms and updates; knows how to access the PIHP Web Site		
Understands the differences between services that are Individual/Family Directed and those that are provider directed		
Knows the difference between Employer of Record and Agency With Choice Models of Individual/Family Directed Supports (if both models offered)		

	Assessment Assistance needed?	
	Yes	No
Understands that a Representative may be appointed at any time, the role of a representative, and the process for appointing a representative		
Understands how the individual and Individual/Family Budgets work, including what is included in each part of the budget, and how to request additional funding in the Individual and Family Directed Supports Budget		
Understands what the Agency With Choice Agreement is and how to work with the Agency With Choice to complete it		
Knows how to contact the Community Guide and the Agency With Choice		
Understands that the Agency With Choice provides Workers Compensation Insurance for employees hired		
Able to interview prospective employees		
Able to work with the Agency With Choice to develop Employee Support Agreements		
Understands how and where to recruit employees		
Able to interview potential employees		
Understands that the Agency With Choice must complete background checks and that the Managing Employer may not review those background checks.		
Understands that the only the Agency With Choice may offer a job to a potential employee		
Understands the purpose of Community Guide Services		
Understands that the Individual Support Plan must be followed (service frequency and duration) and that changes to it must be requested through the Care Coordinator, including how to request additional Community Guide Services		
Knows how to review the Agency With Choice Quarterly Reports, including how to work with the Agency With Choice should there be problems with the Report		
Understands the requirements of the documentation of services		
Understands that the Employer may choose to terminate Individual/Family Directed Supports or transfer to a different Model at any time and also understands that specific processes must be followed		

	Assistance Needed?		
	Yes	No	With AWC
Understands and is able to comply with labor laws that apply to the model selected			

Understands staff qualifications for each service definition and the individual specific staff qualifications			
Understand how and where to recruit employees, including how to request that a newspaper ad be run			
Knows how to develop employee guidelines			
Has resources for employee training; has a plan or training protocols for any training that the Employer is providing			
Understands how to address problems with employees, including documenting those actions, recommending dismissal of employees with poor job performance			
Has a plan for back-up-staffing and has selected a Crisis Services Provider for In Home Intensive, In Home Skill Building and/or Personal Care Services as applicable			
Understands confidentiality requirements for both individual and employee documentation and has established methods for meeting those requirements			
Knows what is billable Medicaid time versus non-billable Medicaid time			
Has developed emergency protocols, has a plan for testing them, and has a plan for documenting those tests			

Notes:

Assessment of Support:

✓ One	The Managing Employer or Representative, if applicable
	Is requesting Community Guide Services to assist with training and support
	Is not requesting Community Guide Services to assist with training and support

Signatures:

Care Coordinator

Date

Person Assessed

Date

cc: Utilization Management Department (with ISP Update requesting self-directed service/AWC model)

Individual Medical Record

Managing Employer and Representative, if applicable

Agency with Choice

Community Guide, if applicable

Description of Duties of Representative

A Representative may be a family member, friend, income payee, or other person who willingly accepts responsibility for performing Managing Employer tasks that the Employer is unable to perform. Representatives must evidence a personal commitment to waiver Participants, and must be willing to follow their wishes and respect their preferences while using sound judgment to act on their behalf. Representatives receive no monetary compensation, and may not serve as a service provider for the Participant, with the exception of providing guardianship services. The Representative may not be known to have any history of physical, mental, or financial abuse, or to have been excluded from participation in the Medicare or Medicaid Programs. The Representative must also meet the following requirements:

- Demonstrate knowledge and understanding of the Participant's needs and preferences, and respect those preferences
- Agree to a predetermined level of contact with the Participant
- Is at least 18 years of age
- Is willing and able to comply with program requirements, including attending required training, and reading manuals/handbooks that describe program regulations
- Is approved by the Employer to act in this capacity

Specific duties of the Representative are:

- Work with the Employer, Care Coordinator, Financial Support Agency or Agency With Choice, and/or Community Guide to assure that the Employer responsibilities are completed
- Make all or some of the decisions for the Employer, depending on the waiver Participant's and Employer's desires and abilities to make those decisions
- Manage, with the Employer, the Individual and Family Directed Supports Budget, using it for services stated in the ISP
- Manage, with the Managing Employer, the Employer functions
- Maintain records as required.

NC Innovations Representative Screening Questionnaire

Name:		Record Number:
Name of Proposed Representative:		
Mailing Address of Proposed Representative (street address):		
City:	State:	Zip Code:
Day Telephone:	Evening Telephone:	
Emergency Contact Name:		
Emergency Contact Telephone Number:		
What is your relationship with the individual (including how long you have known the individual and how frequently you have contact):		
Do you receive money from the individual or anyone else to care for the individual? Yes ____ No ____ If yes, identify source and purpose of the funds:		
After reading the description that outlines the responsibilities of the Representative, do you understand your duties and are you willing to volunteer to serve as the individual's Representative and comply with program requirements? Yes ____ No ____		
Do you understand that you cannot pay yourself for this role and cannot become a paid provider? Yes ____ No ____		
Are you willing to meet with the individual and Employer at least monthly? Yes ____ No ____		
Are you at least 18 years old? Yes ____ No ____		
Do you have any history of physical, mental, or financial abuse of another individual or their funds? Yes ____ No ____		
Have you been excluded from participating as a provider of Medicaid Services, or have you been convicted of Medicare or Medicaid fraud? Yes ____ No ____		

Individual and Family Directed Supports Training completed (or referral to training made)? Yes ____ No ____

Individual and Family Directed Supports Assessment completed (or scheduled)? Yes ____ No ____

Care Coordinator

Date

cc: PIHP (submit with ISP/Update requesting participant-directed service)
 Individual Medical Record
 Employer (Employer of Record or Managing Employer)
 Representative

NC Innovations Representative Agreement

Name:	Record Number:
Employer:	
Proposed Representative:	
I, as proposed Representative for the above named Employer - have been advised of the requirements of the NC Innovations Individual and Family Directed Supports Option, and have attended the NC Innovations Individual and Family Directed Supports Training. I have had an opportunity to have my questions answered. - have read and understand the <u>Individual and Family Supports Employer Handbook</u>. - understand that I may, with the Employer's consent, use Community Guide Services to provide on-going training and consultation in the implementation of Individual and Family Directed Supports. - understand that I cannot be paid for being the Representative, and that I must comply with PIHP, State and Federal requirements for Employer duties. - understand that if I do not follow these requirements that I may be removed as this Employer's Representative. - understand that the Employer may elect to remove me as the Representative at any time. I agree to serve as the Representative for the above named Employer, and understand my responsibilities and duties under the Individual and Family Directed Supports Option of the NC Innovations Waiver. I have read and signed an Individual and Family Supports Agreement that specifies the duties that the Employer has requested that I perform, and agree to abide by terms of this Agreement. I understand that my appointment as Representative is subject to approval by the PIHP. _____ Representative Signature _____ Date _____ Care Coordinator _____ Date	

cc: Employer
 Representative
 PIHP (send with ISP/Update requesting self-directed service)
 Individual Medical Record

NC Innovations Designation of Authorized Representative

Name:	Record Number:
Employer:	
Prospective Representative:	
Representative Type: ☐ Voluntary ☐ Mandatory	
I hereby designate _____ to serve as my Representative in the Individual and Family Directed Supports Option of the NC Innovations Waiver. I understand that I will remain the Employer and retain the status and any liability associated with my role as Employer. I understand that my appointment of a Representative is subject to approval by the PIHP. <i>(Please check one of the following.)</i> ☐ My Representative will complete and sign all forms and send information to the PIHP as required. My Representative will direct supports on the Individual Support Plan, and assume all Employer duties, as Managing Employer. ☐ My Representative will only assume the duties listed on the Individual and Family Directed Supports Agreement that I have designated. I understand that my Representative receives no monetary compensation for acting as my Representative. I may revoke this appointment at any time by notifying my Care Coordinator.	
_____ Employer	_____ Date
_____ Witness	_____ Date

cc: Employer
 Representative
 Care Coordinator
 Utilization Management Department (with ISP/Update requesting approval of self directed service)
 Individual Medical Record

Individual and Family Directed Supports Agreement: Employer of Record

Individual _____ Record Number _____

Purpose

The purpose of this Agreement is to define responsibilities of the Employer of Record (Employer) and Representative, if applicable, in the Individual and Family Directed Supports Option, Employer of Record Model, of the North Carolina Innovations waiver.

Parties to the Agreement

- _____, the Employer of Record (an individual who participates in the NC Innovations waiver, parents of a minor child who participates in the NC Innovations waiver, or legal guardian of an individual in the NC Innovations waiver)
- _____, Representative, a person who willing accepts responsibility for performing Employer of Record tasks that the Employer of Record is unable to perform
- (PIHP Name) , lead agency for the NC Innovations waiver

Other involved entities, not a party to this agreement

- Community Guide, a provider under contract with the PIHP that assists the individual and/or family in directing services.
- Financial Support Agency, a provider under contract with the PIHP to be an agent for, and provide payroll services for, the Employer.

Overview

A person providing services employed by the Employer or Record is considered an employee of that Employer. The Employer of Record is responsible for making sure that employees and payroll taxes are paid. The Employer does this by authorizing the Financial Support Agency to pay employees and taxes. The Employer may designate a Representative to assist in performing these duties. Employees are not provided with any liability insurance coverage and are not licensed or bonded by the State of North Carolina or the PIHP. The Employer of Record is required by the NC Innovations waiver to carry Worker's Compensation Insurance. Premiums are paid by the Financial Support Agency from the Individual and Family Directed Budget.

Responsibility of the Employer of Record and/or Representative	Employer of Record	Representative	Both
Complete Individual and Family Supports Training			
Involve the individual as outlined in the Individual Support Plan (ISP), and provide services as written in the ISP and defined in NC Innovations services			
Ensure that the Individual's health and safety are not at immediate risk			
Participate in the development of the ISP, make decisions about the best way to meet the needs of the individual, including the responsible use of the			

Individual and Family Directed Supports Budget			
Complete hiring packages for employees including making sure employees provide the Financial Support Agency with a copy of their Social Security Card			
Acquire/maintain Worker's Compensation Insurance			
Decide special skills and training employees need; train or arrange for training of employees as required in the Employer Handbook			
Find and hire people to provide services; replace (fire) employees when necessary			
Request background checks including providing information to the Financial Support Agency needed to perform these checks and payroll functions prior to hiring applicant			
Communicate clearly and openly with the Care Coordinator, Financial Support Agency, Community Guide, and employees			
Decide how much to pay the employee, benefits to offer the employee, job duties, and work schedule by requesting and using the Auto Calculator. My Community Guide may request the Auto Calculator on my behalf			
Send a copy of the completed Auto Calculator to the Financial Supports Agency if I do not use Community Guide services			
Complete an Employee Support Agreement for each person hired and a Financial Support Agreement; update agreements as necessary			
Give direction and feedback to employees			
Authorize payment for employees for time worked; send timesheets to the Financial Support Agency per the payroll schedule			
Develop reliable back-up plans for coverage when employees are absent, and plan for potential emergency situations			
Approve billing of Innovation Services provided by the employee(s) and makes sure service documentation is completed by employees			
Retain documentation for 11 years after the last date of service for adults and 12 years after the last date of service for minors after the minor reaches the age of 18. If Employer leaves the Individual Family Directed option the Employer must return all clinical documentation to the PIHP Quality Management Department			
Review monthly reports from the Financial Support Agency, keep track of the balance of the Individual Budget, and stay within that Budget			

Comply with NC Innovations, state and federal requirements for hiring and employing workers, including observing all tax and employment laws			
Keep information about the Individual and employees confidential unless authorized to release			
Complete Incident Reporting as required by the NC Innovations waiver, the PIHP, and the State of NC.			
Notify the Care Coordinator if the ISP or Individual and Family Directed Budget need to be changed			
Participate in evaluating the effectiveness of services and inform the Care Coordinator of difficulties encountered			
Notify the Care Coordinator of admission to a hospital, intermediate care facility (group home or developmental center); or other facility			
Produce all records for the PIHP, State, or Federal Audits/monitoring, and complete Plans of Correction required as a result of those audits, including bringing records to the designated site when requested			
Accept the decision of the PIHP regarding need for a Representative and/or Community Guide Services			
Check the Medicaid card to ensure that the individual continues to be eligible for the NC Innovations waiver.			
The Employer will meet their monthly Medicaid spend down (deductible) if it determined by DSS that this is required for Medicaid eligibility.			

Responsibilities of the PIHP

- Provide/arrange for Care Coordination
- Provide an Orientation to the Individual and Family Directed Supports Option to all Employers of Record and Representatives: refer Employer and Representatives for Individual and Family Directed Supports Training
- Assess Employers of Record for participation in the Option, the need for a Representative, and Community Guide Services
- Facilitate the development of an Individual Support Plan
- Approve ISPs and ISP Updates; authorize the Individual and Family Directed Supports budget and services
- Contract with Financial Support Services and Community Guide Agencies on behalf of Employers of Record and Representatives
- Ensure that the Care Coordinator, Community Guide, and Financial Support Services have the skills and knowledge to assist Employers of Record and Representatives in directing services and supports
- Provide written materials about the Option through contacts with Community Guide Agencies, including the NC Innovations Individual and Family Guide and the PIHP Individual and Family Directed Support Employer Handbook

- Monitor services that the Individual receives
- Share information, experiences and best practices between all parties involved

Consequences for non-compliance with NC Innovations Policies and Procedures

As Employer of Record, or Representative, I understand that the individual may be removed from Individual and Family Directed Supports Option if I mismanage the Individual Budget or do not follow its rules and regulations. I also understand that the Budget is the sum total of funds available for the Individuals plan year, and must be used for authorized services that meet the Individual's needs. No additional funds are available. If an emergency arises, I can request additional funds under NC Innovations procedural guidelines. If I defraud Medicaid, I may be responsible for reimbursing the PIHP for unauthorized expenditures. I further understand that the PIHP may contact my employees and review my records to discuss and verify provision of services to the Individual.

If I am removed from Individual and Family Directed Supports, I must notify my employees that the Financial Support Services Agency will no longer issue their paychecks, and that any further employee/employer arrangements between the employer/employee are not subject to NC Innovations funding regulations and protections.

I agree to uphold all terms of this Agreement. I further agree to hold harmless the State of North Carolina and the PIHP, their representatives and employees from the consequences of my choices as Employer of Record or Representative in Individual and Family Directed Supports. Should I desire to obtain advocacy services from an agency independent of the PIHP, I can contact Carolina Legal Assistance or another advocacy organization listed in my NC Innovations Individual and Family Guide.

	_____ Signature of Employer of Record	_____
Date		
	_____ Signature of Representative	_____
Date		
	_____ Signature of Care Coordinator	_____
Date		

cc: Employer of Record/Representative
Utilization Management Department
Individual Medical Record

Individual and Family Directed Supports Agreement: Managing Employer

Individual _____ Record Number _____

Purpose

The purpose of this Agreement is to define responsibilities of the Managing Employer (Employer) and Representative, if applicable, in the Individual and Family Directed Supports Option, Agency with Choice Model, of the North Carolina Innovations waiver.

Parties to the Agreement

- _____, the Managing Employer (an individual who participates in the NC Innovations waiver, parents of a minor child who participates in the NC Innovations waiver, or legal guardian of an individual in the NC Innovations waiver)
- _____, Representative, a person who willing accepts responsibility for performing Managing Employer tasks that the Managing Employer is unable to perform
- (Insert name of the PIHP), lead agency for the NC Innovations waiver

Other involved entities, not a party to this agreement

- Community Guide, a provider under contract with the PIHP that assists the individual and/or family in directing services
- Agency With Choice, a provider under contract with the PIHP who serves as the employer of employees hired to provide self-directed services

Overview

A person providing services employed by the Agency With Choice is considered an employee of that Agency. The Agency is responsible for making sure that employees and payroll taxes are paid. The Managing Employer functions as co-employer of the employees. The Managing Employer may designate a Representative to assist in performing these duties. Employees are not provided with any liability insurance coverage and are not licensed or bonded by the State of North Carolina or the PIHP. The Agency of Choice carries Worker's Compensation Insurance on the employees.

Responsibility of the Managing Employer and/or Representative	Managing Employer	Representative	Both
Complete Individual and Family Supports Training			
Involve the Individual as outlined in the Individual Support Plan (ISP), and provide services as written in the ISP and defined in NC Innovations services			
Ensure that the Individual's health and safety are not at immediate risk			
Participate in the development of the ISP, make decisions about the best way to meet the needs of the Individual, including the responsible use of the Individual and Family Directed Supports Budget			

Responsibility of the Managing Employer and/or Representative	Managing Employer	Representative	Both
Assist the Agency With Choice and employees in the completion of hiring packages			
Assist employees in reporting on the job injuries to the Agency With Choice			
Decide special skills and training employees need; work with the Agency With Choice to assure that employees are trained per Innovations and ISP requirements			
Refer prospective employees to the Agency With Choice and recommend dismissal of employees to the Agency			
Communicate clearly and openly with the Care Coordinator, Agency With Choice, Community Guide, and employees			
Work with Agency With Choice to determine employee job duties, and work schedule			
With Agency With Choice, complete an Employee Support Agreement for each person hired and an Agency With Choice Agreement; update agreements as necessary			
With Agency With Choice, give direction and feedback to employees and sign time sheets as requested by Agency			
Develop reliable back-up plans for coverage when employees are absent, and plan for potential emergency situations			
Review monthly reports from the Agency With Choice; utilize services as written in ISP			
Comply with employment laws as requested by Agency With Choice			
Notify the Care Coordinator if the ISP or Individual and Family Directed Budget need to be changed			
Participate in evaluating the effectiveness of services and inform the Care Coordinator of difficulties encountered			
Notify the Care Coordinator of admission to a hospital, intermediate care facility (group home or developmental center); or other facility			
Accept the decision of the PIHP regarding need for a Representative and/or Community Guide Services			
The Employer will meet their monthly Medicaid spend down (deductible) if it determined by DSS that this is required for Medicaid eligibility.			

Responsibilities of the PIHP

- Provide/arrange for Care Coordination
- Provide the Individual and Family Directed Supports Option orientation materials to all Employers of Record and Representatives
- Refer Employer and Representatives for Individual and Family Directed Supports Training
- Assess Managing Employers for participation in the Option, the need for a Representative, and Community Guide Services
- Facilitate the development of an Individual Support Plan
- Approve ISPs and ISP Updates; authorize the Individual and Family Directed Supports budget and services
- Contract with Agencies With Choice and Community Guide Agencies on behalf of Employers of Record and Representatives
- Ensure that the Care Coordinator, Community Guide, and Agency With Choice have the skills and knowledge to assist Employers of Record and Representatives in directing services and supports
- Provide/arrange for provision of written materials about the Option, including the NC Innovations Individual and Family Guide and the PIHP Individual/Family Directed Supports Employer Handbook
- Monitor services that the Individual receives
- Share information, experiences and best practices between all parties involved

Consequences for non-compliance with NC Innovations Policies and Procedures

As Managing Employer, or Representative, I understand that the individual may be removed from Individual and Family Directed Supports Option if I mismanage the Individual and Family Directed Budget or do not follow its rules and regulations. I also understand that the Budget is the sum total of funds available for the individual's plan year, and must be used for authorized services that meet the individual's needs. No additional funds are available. If an emergency arises, I can request additional funds under NC Innovations procedural guidelines.

I agree to uphold all terms of this Agreement. I further agree to hold harmless the State of North Carolina and the PIHP, their representatives and employees from the consequences of my choices as Managing Employer or Representative in Individual and Family Directed Supports. Should I desire to obtain advocacy services from an agency independent of the PIHP, I can contact Carolina Legal Assistance or another advocacy organization listed in my NC Innovations Individual and Family Guide.

 Signature of Managing Employer

 Date

 Signature of Representative

 Date

 Signature of Care Coordinator

 Date

cc: Employer of Record/Representative
Utilization Management Department
Individual Medical Record

**INNOVATIONS INCIDENT REPORTING
FOR FAILURE TO PROVIDE BACK-UP STAFFING**

Consumer's Name: _____

Consumer DOB: _____

County of Service Provision:

Date of Incident: _____

Time of Incident: _____ ☐ AM☐ PM**Location where services were scheduled to occur:** _____

Name of person(s) who discovered issue: _____

Name of Provider Agency: _____

Contact Number: _____

Provider Agency Address: _____

Name of Provider to provide staffing: _____

Contact Number: _____

☐ ***Back-up staffing not available (as applicable)***

Indicate name of service(s): _____

Indicate the number of hours consumer was without staff: _____

Indicate specific reason back-up staffing was not available: _____

What options were provided to the consumer/legally responsible person? _____

Who was notified of the incident (list names)? _____

How was the consumer's health and safety ensured? _____

How was time covered? _____

What follow-up was provided to consumer/legally responsible person? _____

What corrective measures will your agency implement to prevent this from occurring in the future? _____

☐ *Back-up staffing offered but declined by consumer/legally responsible person (as applicable)*

Indicate name of service(s): _____

Indicate the number of hours consumer was without staff: _____

Indicate reason consumer/legally responsible person declined back-up staffing: _____

Who was notified of the incident? _____

Signature/Credentials of person completing form:

_____ Date: _____

Supervisor Action: ☐ Action Pending ☐ Action Complete

Signature/Credentials

_____ Date:

Quality Management Action: ☐ Action Pending ☐ Action Complete

Signature/Credentials

Date: _____

Staff hired to provide these services prior to the effective of NC Innovations in the PIHP will have six months to meet the designated competences described in this Appendix.

Staff Competencies: Community Guide

- Completion of training within one year of date of employment that provides instruction in assisting participants and family members in developing support networks that include natural (unpaid) and other community supports.
- Knowledge of and ability to assist the participant in forming and sustaining a full range of relationships with natural and community supports that allows the participant meaningful community integration and inclusion
- Ability to provide support to increase the participant's opportunity to expand valued social relationships and build connections within the individual's local community
- Ability to assist participants in locating and accessing non-Medicaid community supports and resources
- Ability to effectively advocate for participants with intellectual and other developmental disabilities and collaborate with legal guardians, family members, service providers, professionals and members of the community on behalf of the participant the community guide is supporting
- Ability to assist parents/guardians of participants in Individual Education Plan Meetings , including an understanding of the Individuals with Disabilities Education Act (IDEA)
- Knowledge of NC Innovations waiver Goals, Policies and Procedures, including Individual and Family Directed Supports
- Understands the role of the Community Guide and the role of the Care Coordinator
- Effective interpersonal skills that consistently respect participants and family members and their ability to make choices and take risks
- Ability to develop and maintain positive relationships with community agencies, and to guide the participant in making connections in the community
- Understands Principles of Self-Determination
- Ability to support participants and employers in managing the Participant-directed (Individual and Family Directed) Budget
- Ability to train participants, Employers and/or Representatives in Individual and Family Directed Supports
- Ability to train and support participants in recommending hiring, managing, and if necessary, recommending firing employees
- Ability to train and assist Employers in submission of employee hiring packages
- Ability to train and assist Employers in locating resources or developing training for employees
- Understands the role of the Agency with Choice, and able to maintain effective working relationships with the Agency with Choice
- Ability to assist Employers in developing and/or completing Agreements
- Trained or experienced in conflict resolution and/or mediation
- Trained in and adherence to NC Client Rights Rules in Community Training, including ability to assist Employers in complying with Client Rights Rules
- Trained in Health Insurance and Portability and Accountability Act (HIPAA)
- Trained in Cultural Diversity
- Ability to work flexible hours to meet the needs of participants/employers

Staff Competencies: Crisis Services

- Knowledge of NC Innovations waiver Goals, Policies and Procedures
- Interpersonal Skills (oral and written) that consistently respect participants and family members that facilitate clear, concise communication in a crisis situation
- Trained or experienced in conflict resolution and/or mediation
- Trained in and adherence to North Carolina Client Rights Rules
- Trained in HIPAA
- Trained in North Carolina DMH/DD/SAS Incident Reporting
- Trained Cultural Diversity
- Trained in and knowledge of the ISP, Crisis Plan and Behavior Support Plan for each participant supported as appropriate.
- Trained in a form of non-violent crisis intervention to include preventative first approach strategies (i.e. NCI, PMAB, Getting It Right etc.)
- Trained in identification of antecedent crisis behaviors
- Trained in Positive Behavior Support Plans
- Competent in documentation to support data driven outcomes
- Competent in specific developmental disabilities diagnosis inclusive of co-occurring Mental Health Diagnosis
- Knowledge of the PIHP service authorization process
- Knowledge of the PIHP Emergency Services referral process
- Familiarity with the Emergency Service options in the PIHP area.

Staff Competencies: Crisis Behavioral Consultation

- Knowledge of NC Innovations waiver Goals, Policies and Procedures
- Interpersonal skills (oral and written) that consistently respect participants and family members and facilitate clear, concise communication in a crisis situation
- Trained in and adherence to North Carolina Client Rights Rules
- Trained in North Carolina DMH/DD/SAS Incident Reporting requirements
- Trained in HIPAA
- Trained in Cultural Diversity
- Trained in and knowledge of the ISP, Crisis Plan and Behavior Support Plan for each participant supported as appropriate
- Trained in a form of non-violent crisis intervention to include preventative first approach strategies (i.e. NCI, PMAB, Getting It Right etc.)
- Trained in identification of antecedent crisis behaviors
- Trained in Positive Behavior Support Plans
- Competent in documentation to support data driven outcomes
- Competent in specific developmental disabilities diagnosis inclusive of co-occurring Mental Health Diagnosis
- Competent in completing Functional Assessment
- Competent in development of Behavior Support Plans
- Competent in staff training regarding Behavior Intervention and Consultation
- Knowledge of the PIHP service authorization process
- Knowledge of the PIHP Emergency Services referral process
- Familiarity with the Emergency Service options in PIHP area

Staff Competencies: Crisis Out of Home

- Knowledge of NC Innovations Waiver Goals, Policies and Procedures
- Interpersonal Skills (oral and written) that consistently respect participants and family members that facilitate clear, concise communication in a crisis situation
- Trained or experienced in conflict resolution and/or mediation
- Trained in and adherence to North Carolina Client Rights Rules
- Trained in HIPAA
- Trained in North Carolina DMH/DD/SAS Incident Reporting
- Trained Cultural Diversity
- Trained in and knowledge of the ISP, Crisis Plan and Behavior Support Plan for each participant supported as appropriate.
- Trained in a form of non-violent crisis intervention to include preventative first approach strategies (i.e. NCI, PMAB, Getting It Right etc.)
- Trained in identification of antecedent crisis behaviors
- Trained in Positive Behavior Support Plans
- Competent in documentation to support data-driven outcomes
- Competent in specific developmental disabilities diagnosis inclusive of co-occurring Mental Health Diagnosis
- Knowledge of the PIHP service authorization process
- Knowledge of the PIHP Emergency Services referral process
- Familiarity with the Emergency Service options in the PIHP geographic area.

Staff Competencies: Supported Employment

- Demonstrates an understanding of the difference between supported employment and traditional vocational services
- Demonstrates the ability to identify how support strategies can enhance, or detract from the image of a participant
- Demonstrates the rights and responsibilities of participants in supported employment
- Demonstrates an understanding of the benefits of integration at the workplace for participants, including maximizing lunch and break times
- Demonstrates an understanding of group and individual models of supported employment
- Demonstrates the ability to prepare a participant for a job search and maximize participant involvement in that job search
- Demonstrates an understanding of legislation and regulations related to supported employment, including the Americans with Disabilities Act, the Rehabilitation Act, Ticket to Work, Individuals with Disabilities Education Act, the Fair Labor Standards Act and other Department of Labor and Internal Revenue Service laws related to employment
- Demonstrates the ability to provide prospective employers with information related to employer incentives, including tax and other incentives
- Able to appropriately handle employer questions about participant's disability
- Demonstrates the ability to identify and facilitate natural supports within each work site
- Demonstrates the ability to assess company culture including architectural, attitudinal and cultural barriers to employment for participants with disabilities
- Demonstrates the ability to write accurate job descriptions by identifying the essential and marginal functions of a job
- Demonstrates an understanding of job site modifications and accommodations, and can identify resources for those modifications and accommodations
- Demonstrates competence in person centered thinking processes
- Demonstrates the ability to assess the availability of community transportation and train the participant in using community transportation, as applicable
- Understands the impact of participant wages on benefits
- Demonstrates the ability to adhere as closely as possible to typical new employee orientation and training procedures
- Demonstrates the ability to develop strategies to systematically fade prompts and other forms of assistance
- Demonstrates the ability to assist a participant in locating resources and provide other support for developing and operating a micro-enterprise

NC Innovations Community Transition Checklist
Community Transition Anticipated Purchase Checklist

Name _____**Date** _____**Community Guide Agency** _____

	Lease deposit (= < 2 mo. Rent)		Small Household/Kitchen Appliances
	Telephone deposit (no equipment)		Electric/battery clock
	Electric Deposit		Lamps
	Water deposit		Vacuum cleaner
	Moving van rental/expenses		Can opener
	Kitchen		Toaster/toaster oven
	Dishes/plates/bowls/glasses		Microwave
	Utensils-eating/cooking		
	Kitchen towels/dishcloths/scrubbers/potholders		List additional items needed
	Dish drainer		
	Pots/pans/skillet/sauce pan/baking sheet		
	Plastic ware storage		
	Ice cube trays		
	Cutlery/cutting board		
	Trash can		
	Dinette and chairs		
	Living Room		
	Couch/sofa		
	Table/Lamp		
	Bedroom		
	Mattress/box/foundation/frame		
	Dresser/chest		
	Nightstand		
	Sheets/blankets/pillows		
	Bathroom		
	Bath towels/washcloths/mat		
	Toilet plunger/toilet brush		
	Trash container		
	Cleaning		
	Mop, bucket, broom, dust pan		
			EXCLUSIONS ☐ Washer/Dryer ☐ Fridge/Freezer ☐ Dishwasher ☐ Radio/Stereo ☐ Rent, mortgage ☐ Cable, internet ☐ TV, VCR, DVD player ☐ Telephone equipment ☐ Computer ☐ Exercise equipment ☐ Stove

Appendix V – PIHP Transition Effective DatesNorth Carolina Innovations Waiver

PIHPs/Counties and Effective Dates of Transition to NC Innovations

PIHP	Counties	Effective Date of Transition to NC Innovations
PBH	Cabarrus, Davidson, Rowan, Stanly, Union	April 1, 2005
PBH	Alamance, Caswell	October 1, 2011
PBH	Franklin, Granville, Halifax, Vance, Warren	January 1, 2012
Western Highlands	Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	January 1, 2012
East Carolina Behavioral Healthcare (ECBH)	Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, Washington	April 1, 2012
PBH	Chatham, Orange, Person	April 1, 2012
Sandhills	Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond	October 1, 2012
Smoky Mountain	Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes	July 1, 2012

NC Innovations Performance Measures

Indicator #	Report Name	Indicator	Numerator/Denominator
A:7	Slot/transfer tracking	DMA tracks waiver participation through reporting by the PIHP on new enrollees and consumers transferring in from other waivers	
A:10	Waiver Assurance compliance	The PIHP reviews a sample (10% of Record Reviews) of Innovations consumer records, including encounter data, to determine compliance with waiver assurances and reports to DMA as specified below.	Numerator #1: Number of C waiver participants reviewed for Quality Indicators D:2-11 and G:3-4 Numerator #2: Number of # C Waiver participants reviewed for Quality Indicator D:2-13 Denominator: Total Number of C Waiver Participants
A:10 (2)	Provider Capacity	DMA reviews the PIHP Innovations provider network for adequate capacity and choice.	
B:6-9	Level of Care Completion	Proportion of Level of Care evaluations completed within 30 days of identification of need for services	Numerator: Number of LOC evaluations performed within 30 days for a new individual being identified for a C waiver slot Denominator: Total number of LOC evaluations completed for individuals identified for available C waiver slots
B:6-10	Level of Care completed annually	Proportion of Level of Care evaluations completed at least annually for enrolled participants	Numerator: Number of C waiver participants who received an annual LOC re-evaluation Denominator: Total number of C waiver participants with annual plans (not including new enrollees)

Appendix W – Performance Measures
North Carolina Innovations Waiver

B:6-10 (2)	Level of Care process/instrument	Proportion of Level of Care evaluations completed using approved processes and instrument	Numerator: Number of annual LOC evaluations completed using LOC instrument/process for C waiver participants Denominator: Total number of C waiver participants due for an annual plan
C:2-8	Provider Standards	Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	Numerator: Number of new C waiver providers reviewed who meet the requirements to furnish C waiver services Denominator: Total number of new C waiver providers who were reviewed
C:2-9	Provider Compliance	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	Numerator: Number of C waiver providers who had a review completed Denominator: Total number of C waiver providers scheduled for a review
C:2-10	Provider Remediation	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	Numerator: Number of C waiver providers submitting an approved plan of correction (POC) Denominator: Total number of C waiver providers from which a POC was requested
D:2-8	ISP assessed needs/goals	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Numerator: Number of Individual Support Plans for C waiver participants that meet/support goals Denominator: Total number of Individual Support Plans for C waiver participants
D:2-9	ISP Health and Safety Risk	Proportion of Individual Support Plans that address identified health and safety risk factors	Numerator: Number of Individual Support Plans for C waiver participants that meet all risk elements Denominator: Total number of Individual Support Plans for C waiver participants

Appendix W – Performance Measures
North Carolina Innovations Waiver

D:2-9 (2)	ISP Service Needs	Percentage of participants reporting that their Individual Support Plan has the services that they need	Numerator: Number of C Waiver participants who reported their Individual Support Plans have the services they need Denominator: Total number of Individual Support Plans for C Waiver participants
D:2-10	ISP Performance Measures	The State requires the PIHP to report results of performance measures related to the service plan to DMA and the Intra-Departmental	Numerator: Number of performance measures completed and reported to State Denominator: Number of performance measures the PIHP is required to complete and report to the State
D:2-11	ISP Annual Updates/Needed Updates	Proportion of individuals for whom an annual plan and/or needed update took place	Numerator: Number of C waiver participants reviewed for whom all annual Individual Support Plans and needed updates took place Denominator: Total number of Individual Support Plans that needed a change/update for C waiver participants
D:2-12	Services Rec'd within 45 days	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval.	Numerator: Number of new C waiver participants who receive services within 45 days of approval of the ISP Denominator: Total Number of initial ISP's for new C waiver participation
D:2-13	ISP & Specified Services	Proportion of participants who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	Numerator: Number of new C waiver participants reviewed who received services in the type, scope and frequency listed in the ISP Denominator: Total number of C waiver participants reviewed
D:2-14	Freedom of Choice Statements	Proportion of records that contain a signed freedom of choice statement	Numerator: Total number of Individual Support Plans for C waiver participants where freedom of choice statement is signed Denominator: Total number of Individual Support Plans for C waiver participants

Appendix W – Performance Measures
North Carolina Innovations Waiver

D:2-14 (2)	CC Advises on Available Services	Proportion of participants reporting their Care Coordinator helps them to know what waiver services are available	Numerator: Number of Individual Support Plans for C waiver participants that indicate the Care Coordinator helps the participant know what services are available Denominator: Total number of Individual Support Plans for C waiver participants
D:2-15	Provider Choice	Proportion of participants reporting they have a choice between providers	Numerator: Number of Individual Support Plans for C waiver participants that indicate the participants were given a choice of providers Denominator: Total number of Individual Support Plans for C waiver participants
G:3-4	Health & Welfare Monitoring	Proportion of waiver participants whose health and welfare is monitored according to the waiver process and Care Coordinator Monitoring Tool	Numerator: Number of C waiver participants reviewed whose health and welfare is reviewed according to the Care Coordinator Tool Denominator: Total number of C waiver participants reviewed
G:3-4 (2)	Health & Welfare Issues Resolved	Proportion of waiver participants for whom health and welfare issues are discovered and appropriate remediation took place	Numerator: Number of C waiver participants reviewed for whom all health and welfare issues were identified, substantiated and were appropriately remediated Denominator: Total number of C waiver participants for whom an incident report was received
I:1-2	Innovations Claims vs. Services Auth'd	The proportion of claims paid by the PIHP for Innovations wavier services that have been authorized in the service plan.	Numerator: Number of C waiver claims paid for services that have been authorized by Utilization Management (UM) Denominator: Total number of C waiver claims paid

NC Innovations: DSS Sample Letter**Memorandum**

To: DSS Eligibility Specialist
County

From: Name and Contact at PIHP

Date:

RE: Request for NC Innovations Waiver Indicator
Consumer's Name
Consumer's MID

The PIHP has approved the above individual to participate in the NC Innovations waiver.

Please enter the NC Innovations indicator and effective date in the Eligibility Information System. The NC Innovations indicator to be placed in the Individual Data Special Use block is **IN**.

The effective date for NC Innovations waiver participation is the Level of Care effective date listed below:

- Date of Medicaid application _____
- Level of Care Approval Date _____
- Date of Deinstitutionalization _____

Attached, you will find a copy of the Individual Budget which contains the approved Medicaid waiver services for this person. If this person has a Medicaid deductible/spend down please notify our office. A copy of the NC Innovations Level of Care Determination form is attached for your review.

**Unlicensed AFL Review Form
(LME Name)
NC Innovations Unlicensed AFL On-Site Review Form**

Provider Agency: _____
 Date of On-Site Review: _____
 Location Site: _____ County: _____
 AFL Provider: _____
 Reviewer's Name: _____
 Provider Staff Name: _____

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
First Aid supplies are stocked/current (<i>first aid kit</i>)			
Fire escape plan- recommend semi- annual practice tests per Waiver year			
Backup plan for caregiver illness			
Readiness for severe weather - plan			
Medical emergency plan/contact numbers/medical information for consumer			

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
Criminal background checks for all people over 16 years old residing in home			
Meals meet nutritional needs and are related to needs on person centered plan (i.e. low fat, diabetic standards etc.)			
Client privacy and visitation assured			
MEDICATIONS			
If the home administers: ☐ Secure ☐ Documented			
☐ Documentation of caregiver med training OR ☐ Documentation of individual's ability to self medicate			
Is there enough storage for individual's personal belongings?			

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
Home Environment			
UL approved fire extinguishers Number_____			
Smoke Detectors located: - o Sleeping room - o Outside of sleeping area - o Each story of the dwelling			
Flammables in excess of 25 gallons (excluding fuel oil for heating) can not be within the dwelling, or attached/detached garage			
Easy entry and egress from home for client- thumb latch dead bolt locks are permitted (NO deadbolt locks needing a key for interior use)			

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
Emergency egress- Each sleeping room has at least 1 working window or door for emergency exit			
Emergency exit operable without key or tool and leads to a full clear opening			
Water temperature between 100-116			
Approved drinking water source: o City Water o Well Water			
Easy access/egress to appropriate and private toilet, bathing and person hygiene facilities			
Bathroom have ventilation			
Electrical Appliances			
Range hoods/dryer are vented to the outside			

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
GFI outlets are required in bathrooms, kitchen counters tops, wet bars, garages, crawl spaces, outdoors or unfinished basements (<i>DFS standard for non licensed facilities</i>)			
Safe and appropriate appliances for heating and cooling: Note supervision of the appliances use: - o Electric - o Gas - o Oil - o Not sole heat source			
Garages do not open into a sleeping room			
Enclosed/Accessible under stair storage space should be walled; walls and any electrical outlets are protected.			
Stair landing is at any door opening (i.e. screen and storm doors excluded)			

Check the Following	Y/N – ID Problem	Recommendation for Problem	Correction Completed
Sturdy railing present on porches, balconies or raised flooring surfaces of 30” above grade			
Adequate lighting in stairways, halls and exits including exterior exit lighting			
Identify hazardous conditions (outdoor decking, swimming pools, exposed car ports etc.)			

Additional Discussion/Recommendation Points with expected completed date:

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NC Innovations Billing for Residential Support is:

- ☐ Recommended due to unlicensed AFL meeting satisfactory standards
- ☐ Not recommended due to unlicensed AFL not meeting satisfactory standards

LME Approved Signature and Date: _____

[Date]

[LRP/Guardian]

[Address]

RE: Non use of one NC Innovations Waiver Service

[Dear],

This letter is in reference to your participation in the NC Innovations Waiver. State and federal guidelines for the use of Medicaid Waiver funding require the provision of at least one waiver service on a monthly basis in order for an individual to remain on the waiver. Based on a review of services delivered to you, you have not utilized waiver services at least monthly since [date of last use]. Currently you are authorized to receive the following NC Innovations service (s) [insert service].

The Centers for Medicare and Medicaid Services (CMS) Review Criteria reads as follows “In order for an individual to be considered to require a level of care specified for the waiver, it must be determined that: (a) the person requires at least one waiver service (as evidenced by the service plan) and (b) requires the provision of waiver services at least monthly, or if less frequently, requires monthly monitoring (as documented in the service plan) to assure health and welfare. Individuals may not be enrolled in the waiver for the sole purpose of enabling them to obtain Medicaid. Entrance to the waiver is contingent on a person’s requiring one or more services offered in the waiver in order to avoid institutionalization.”

At this time, you are not meeting this requirement. You are currently authorized to receive [insert services, units, dates authorized]. If you continue to be interested in NC Innovations Services, please work with your Care Coordinator to re-engage in service use by [30 days from date of this letter]. Should waiver services not be utilized by [30 days from date of this letter], [Insert PIHP Name] will potentially terminate your enrollment in the NC Innovations Waiver.

Should you have questions or need clarification, please do not hesitate to contact me at [Insert contact information]

Sincerely,

The Appeals Chart for the NC Innovations Waiver Technical Guide is currently under review by the NC Attorney Generals.