



North Carolina Department of Health and Human Services  
**Division of Medical Assistance**

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Beverly Eaves Perdue, Governor  
Lanier M. Cansler, Secretary

Craig L. Gray, MD, MBA, JD, Director

March 25, 2010

Ms. Cheryl L. Brimage, MHA  
Health Insurance Specialist  
Centers for Medicare and Medicaid Services  
Division of Medicaid & Children's Health Operations  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303

Subject: Amendment to the NC Innovations waiver, Control #NC-02.R02.01

Dear Ms. Brimage:

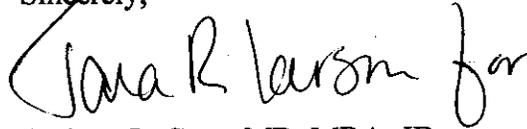
We are writing to request an amendment to the above referenced waiver regarding the acuity-based support need matrix to be piloted by Piedmont Behavioral Healthcare (PBH) and the transition plan for PBH in implementing service changes recently approved by CMS. The amended replacement pages are enclosed. Specifically, we are requesting approval of the following changes:

- Application, page 7- The effective date of the amendment submitted on December 15, 2009 has been corrected to April 1, 2010.
- Attachment #1 Transition Plan, pages 12-13 – The transition plan clarifies that the current contractor, PBH, will begin implementing and testing the new support need matrix for new participants effective April 1, 2010 and for existing participants effective July 1, 2010.
- Attachment #1 Transition Plan, pages 12-13 – The transition plan for the current contractor, PBH, to begin phasing in new services and changes in provider qualifications to existing services will be effective with the addition of new capitated entities as approved by CMS. (This is consistent with the approved effective dates for other waiver changes resulting from expansion.)
- Appendix C-2, page 8 - Relatives as providers is applicable to the new Personal Care service. (This is not a change. Relatives were allowed to be providers for the personal care component of the former Home Supports service in the Innovations waiver prior to the expansion amendment.)
- Appendix C-3, page 3: Relatives as providers is applicable to the new Personal Care service. (This is not a change. Relatives were allowed to be providers for the personal care component of the former Home Supports service in the Innovations waiver prior to the expansion amendment.)
- Appendix c-4, pp 1-5: A detailed description of the support need matrix to be piloted by PBH has been added.



Please contact Judy Walton if you have questions or need additional information. Judy can be reached at 919-855-4265 or at [judy.walton@dhhs.nc.gov](mailto:judy.walton@dhhs.nc.gov). We look forward to hearing from you soon and, as always, appreciate your assistance and support of our waiver programs.

Sincerely,



Craig L. Gray, MD, MBA, JD

cc: Tara Larson  
Leza Wainwright  
Ken Marsh  
Catharine Goldsmith  
Kelly Crosbie  
Susan Johnson  
Judy Walton



## Application for a §1915 (c) HCBS Waiver

### HCBS Waiver Application Version 3.5

Submitted by:

Division of Medical Assistance  
North Carolina Department of Health and Human Services

Submission  
Date:

CMS Receipt Date (CMS  
Use):

*Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:*

#### Brief Description:

**This is a request to amend the North Carolina Innovations HCBS waiver (CMS Control #0423.01), effective April 1, 2010. The NC Innovations waiver supports people with intellectual and other developmental disabilities in a five-county service area.**

**The existing 1915(c) waiver is being modified to reflect that the program will no longer be a pilot with a single capitated provider in a limited geographic area and will reflect the anticipated phase-in schedule. The statewide policies will be reflected in the initial 1915(b) and 1915(c) waiver modifications. At the point in time when the actual capitated entities and exact counties to be included in each stage of the phase-in are known, waiver amendments and contracts reflecting this additional knowledge will be submitted for CMS approval.**

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The BH managed care initiative includes this request to the CMS for the modification of the existing 1915(c) NC Innovations HCBS waiver, as well as a simultaneous amendment to the NC MH/DD/SAS 1915(b) Freedom of Choice waiver. Through the operation of the concurrent CMS authorities, DHHS will select and initially contract with one to two additional regional PIHPs meeting technical criteria for CMS regulatory requirements, as well as industry standards for financial, administrative and clinical operations. Those technical criteria will be outlined in a Request for Application to be issued early next year, outlining the requirements necessary to expand the program to a larger geographic region with the goal of eventual statewide implementation. Other PIHPs will be phased in as networks become available in their respective counties.

The existing 1915(b) and 1915(c) waivers will be modified to reflect that the program will no longer be a pilot with a single capitated provider in a limited geographic area and will reflect the anticipated phase-in schedule. The statewide policies as well as the costs for the entire state will be reflected in the initial 1915(b) and 1915(c) waiver modifications. At the point in time when the actual capitated entities and exact counties to be included in each stage of the phase-in are known, waiver amendments and contracts reflecting this additional knowledge will be submitted for CMS approval.

### Transition to the PIHP services:

For the participants transitioning from the Support and Comprehensive waivers, the transition will be seamless for the new MH/DD/SAS waiver services to the extent waiver providers are in the PIHP network. The participants' PCP will continue be reviewed as needed due to changes in care needs or on an annual basis during their birth month. Services have been added to the NC Innovations waiver to ensure individuals currently receiving services in the Supports and Comprehensive waiver will continue to receive services.

### Transition for the current PBH provider:

Effective April 1, 2010 the current contractor (PBH) will:

- Implement the first-come, first-serve waiver access policy
- Increase allowable bed size to 6 for existing facilities
- Expand existing waiver capacity as outlined in Appendix J
- Implement the new cost limit of \$135,000 (Any existing Innovations participants who exceed the cost limit will be "grandfathered in" under their existing budget.)
- Begin implementing and testing the acuity-based support need matrix for new participants. (See information below on the new support need matrix.)

Effective July 1, 2010, the current contractor (PBH) will:

- Finalize and implement the acuity-based support need matrix for existing waiver participants.
  - The acuity based support matrix is designed to standardize funding among participants who have similar support needs and reflects assessment derived levels of need, age and cost limit. Current waiver participants will have their support need matrix level phased in over twelve months, in four month increments, to begin at the time of their annual PCP. This phase-in is needed

to allow sufficient time for waiver participants and planning teams to work collaboratively to ensure that service needs are met. The Care Coordinator may call a team meeting in the event of an increased need for service by a waiver participant. If the team determines that a need for increased services by a waiver participant exists, safeguards are available to address this need up to the \$135,000 cost limit. Care Coordinators will inform participants of their right to a Fair Hearing.

Effective with the first day of implementation of any new capitated entities which are approved for waiver participation by CMS, the current contractor (PBH) will:

- Use Murdoch as the evaluator of LOC, as will new capitated entities.
- Begin phasing in the new services (i.e., personal care, in-home skill building, and intensive in-home support) and phasing out the current Home Supports; phase-in will take place according to birth month (when the PCP is up for renewal).
- Implement the changes to the provider qualifications in existing services.

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

<input type="checkbox"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="checkbox"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>

The following relatives may provide services: legal guardians, parents of adult participants and other relatives who live in the home of the participant. Parents of minor children may not be the provider of services for their children. The waiver services that relatives or legal guardians may provide are community networking, day supports, in-home skill building, in-home intensive supports, personal care and residential supports. Payments are made to relatives/legal guardians in the following circumstances:

1. The relative or legal guardian must meet the provider qualifications for the service.
2. 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.
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. A relative and/or legal guardian who resides in the same household as the waiver participant and who exercises the Employer Authority (employer of record) on behalf of the participant in an individual/family directed service arrangement may not furnish a service that is subject to the Employer Authority. The Managing Employer in an Agency with Choice model may not furnish a service that is subject to the manager employer's direction.
5. Provider agencies, employers of record, and managing employers (through the Agency with Choice) must submit documentation to the PIHP to demonstrate that the relative or legal guardian meets the qualifications to provide the service along with the justification for using the relative as the service provider rather than an unrelated provider. The PIHP must prior authorize the provision of services by the relative or legal guardian.
6. 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 ensure the participant's health and welfare.
7. When a relative or legal guardian is the service provider, provider agencies, Employers of Record, and/or the managing employers, as appropriate, monitor the relative's or legal guardian's provision of services on-site, at a minimum of one time per month.
8. When a relative or legal guardian is the service provider, the PIHP care coordinator monitors the relative's provision of services on-site at a minimum of one time per month.
9. Payments are only made for service authorized by the PIHP in the PCP.
10. 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.
11. Biological or adoptive parents of a minor child, stepparents of a minor child or the spouse of a waiver participant are not paid for the provision of waiver services.

## Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
<b>Service Title:</b>	<b>Personal Care</b>
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="checkbox"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="checkbox"/>	Service is not included in the approved waiver.
<b>Service Definition (Scope):</b>	
<p><b>Personal Care Services under North Carolina state 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.</b></p> <p><b>When specified in the PCP, 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 participants' family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation and use of special mobility devices.</b></p> <p><b>Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the supports described in the PCP. Services may be allowed in the private home of the provider or staff of an employer of record if there is documentation in the PCP that the participant's needs cannot be met in the participant's private home or another community location.</b></p>	
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>	
<p><b>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 care homes or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service nor any other state plan personal care service.</b></p> <p><b>This service may not be provided on the same day that the participant receives regular Medicaid personal care, a home health aide visit, residential supports or another substantially equivalent service.</b></p> <p><b>This service may not be provided at the same time of day that a participant receives: Day supports, in-home skill building, community networking, specialized consultation services, respite care, supported employment, or in-home intensive supports.</b></p>	

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

**For participants who are eligible for educational services under the Individuals With Disability Educational Act, in-home personal care 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.**

**The amount of personal care is subject to the "Limits on Sets of Services" specified in Appendix C-4. The amount of personal care is also subject to the amount of the participant's individual budget allocation level as specified in Appendix C-4.**

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Personal Care Self-Employed Individual (Self-Direction Only)		Home Health Agency	
			Personal Care Service Provider	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

**Provider Qualifications** *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify):</i>	Certificate <i>(specify):</i>	Other Standard <i>(specify):</i>
Personal Care Self-Employed Individual (Self-Direction Only)			<p>Staff that work with participants are approved by employer of record or recommended by managing employer and approved by Agency with Choice that work with participants:</p> <ul style="list-style-type: none"> <li>• Are at least 18 years old</li> <li>• 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</li> <li>• Criminal background check presents no health nor safety risk to participant</li> <li>• Not listed in the North Carolina Health Care Abuse Registry</li> <li>• Staff that work with participants must be qualified in CPR and First</li> </ul>

			<p><b>Aid</b></p> <ul style="list-style-type: none"> <li>• <b>Staff that work with participants must have a high school diploma or high school equivalency (GED)</b></li> <li>• <b>Staff that work with participants must be qualified in the customized needs of the participant as described in the PCP</b></li> <li>• <b>Supervised by the employer of record or managing employer</b></li> <li>• <b>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 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 for a two-year period</b></li> <li>• <b>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</b></li> <li>• <b>Agencies with Choice follow the NC State Nursing Board regulations</b></li> <li>• <b>Has an arrangement with an enrolled Crisis Services provider to respond to participant crisis situations</b></li> <li>• <b>Additionally, within one year of waiver amendment implementation or enrollment as a provider, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of</b></li> </ul>
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			<p><b>meeting all of the requirements of the PIHP. This includes national accreditation within the prescribed timeframe</b></p> <p><b>Services provided in private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.</b></p>
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✓	<p><b>Budget Limits by Level of Support.</b> Based on an assessment process and/or other factors, participants are assigned to funding levels that are limited on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i></p>
	<p><b>SEE BELOW</b></p>
	<p>All waiver participants are assigned to a support level on either the Residential Level of Support Need Matrix or the Non-Residential Level of Support Need Matrix (collectively referred to as the “Level of Support Need Matrix”). The Residential Level of Support Need Matrix is applied to those individuals that require residential services and the Non-Residential Level of Support Need Matrix is applied to those individuals that do not require residential services.</p> <p><b><u>Basis of the Budget Limit</u></b></p> <p>The Level of Support Need Matrix is designed to standardize funding among persons who have similar support (acuity) needs and reflects: assessment derived levels of need, age, and budget limit.</p> <p>The assessment instrument used to objectively measure individual supports needs is the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD). The SIS is a validated, reliable instrument for assessing the level of an individual’s supports needs in major domains of daily living as well as behavioral and medical needs. The SIS has been in use by the PIHP for 4 years. PBH is a national norming site for the child version (for children below the age of 16) of the SIS. Extensive training of the dedicated team of local SIS interviewers has been successfully completed by two SIS authors. This training has included both the adult version of the SIS and the child version of the SIS. The SIS tool has been enhanced by the addition of supplemental questions that include four topics: community safety risk (convicted and not convicted), extreme self-injury risk, and extraordinary medical care (risk) for individuals whose supervision for those concerns requires 24 hour eyes on supervision.</p> <p>The levels of need (Levels 1 through 8) were adopted from work performed by other jurisdictions employing the SIS as the assessment instrument in HCBS waiver resource allocation models. These levels were derived based on the SIS assessments, additional information concerning the participants’ living arrangement (e.g., lives with family or resides in a community residential setting) and the amount of service expenditures for the individuals assessed.</p> <p>The specific levels of need were derived in other jurisdictions by employing multiple regression analysis and other statistical techniques to identify SIS elements that were statistically significant in explaining differences in service expenditures. The level of need algorithm used by these other jurisdictions has satisfactorily explained</p>

**differences in funding authorizations that stem from differences in objectively assessed supports needs.**

**The Level of Support Need Matrix divides the population by age into adults and children. Children are defined in the Level of Support Need Matrix as less than 22 years of age and adults are defined in the Level of Support Need Matrix as 22 years of age or older.**

**The budget limit for each cell of the Level of Support Need Matrix were developed based on an analysis of historical expenditures of “Base Budget Services” for individuals participating in Innovations, guideline service packages and provider rates to be paid by PBH.**

**The most recent local SIS interviews from the previous Calendar year are made into SIS informed Levels of Support Need during the first quarter of the new Calendar year. The SIS tool is administered at least every two years to all waiver participants. New budget limits will be used in the Level of Support Need Matrix on July 1 of each year beginning in 2010. The Level of Support Need Matrix will be phased in as resources permit during a period not to exceed three years. Matrix. At the end of the phase in the Level of Support Need Matrix will be applicable for all waiver participants.**

#### **Services Included in the Level of Support Need Matrix**

**Waiver services defined as “Base Budget Services” are included in the cost limit of the Level of Support Need Matrix. “Base Budget Services” are:**

- 1. Community Guide Services**
- 2. Community Networking Services**
- 3. Day Supports**
- 4. Home Supports to later be replaced by In-Home Skill building, Intensive In Home Supports and Personal Care**
- 5. Individual Goods and Services**
- 6. Residential Supports**
- 7. Respite**
- 8. Supported Employment**

**Waiver services not included in the definition of “Base Budget Services” are:**

- 1. Assistive Technology Equipment and Supplies**
- 2. Community Transition Services**
- 3. Crisis Services**
- 4. Financial Support Services**
- 5. Home Modifications**
- 6. Natural Supports Education**
- 7. Specialized Consultation Services**

## 8. Vehicle Modifications

The services in “Base Budget” and the services not included in the “Base Budget” together may not total more than the Cost Limit of \$135,000.

### Individual Budget

The budget limits in the Level of Support Need Matrix are the maximum Individual Budget amount that can be authorized in a waiver participant’s Person Centered Plan.

The Care Coordinator (Case Manager), as part of the Person Centered Plan development, will explain the Level of Support Need Matrix, the development process and maximum amount of the Individual Budget, the service authorization process, the mechanisms available to the participant/representative to modify their Individual Budget and the participant’s rights to a Fair Hearing and informal appeals.

A result of the Person Centered Plan development is an Individual Budget that is a component of their Person Centered Plan (PCP). The Individual Budget, once authorized, will represent the total cost of “Base Budget Services” under the waiver to be delivered under the Person Centered Plan. All Individual Budgets are reviewed by the PIHP Access/Utilization Management Department for final determination and authorization of funding.

In developing the Person Centered Plan and the Individual Budget, the planning team will be guided by the level of need assigned to the participant and the cost limit associated with that level of need in the Level of Support Need Matrix. The Care Coordinator will guide the development of the Person Centered Plan such that the resulting Individual Budget for “Base Budget Services” is at or below the appropriate cost limit in the Level of Support Need Matrix.

### Adjustments for Individual Circumstances

The Care Coordinator may call a PCP review meeting in the event of an increased need for service by a waiver participant. If the interdisciplinary team review determines a need for increased intensity of services, the PIHP Access/Utilization Management Department or designee may approve a time limited (not to exceed six months) increase in intensity of services.

If the interdisciplinary team determines that a waiver participant has an extended need for an increased intensity of services (beyond six months), the individual may be authorized a change in living arrangement (from home to a community based residential facility) which will move the participant from the Non-Residential Level of Support Need Matrix to the Residential Level of Support Need Matrix, or re-assessed, and if supported by the results of a new SIS assessment, moved to a higher level of

support need. If the cost limits in the new living arrangement or new level of support need will not meet the participant's support needs, the participant may seek approval for placement in Level 8.

If the Individual Budget and Person Centered Plan cannot be developed for Base Budget Services at or below the Budget limit, the Care Coordinator may prepare a justification for placement of the participant into Level 8 based on the unique behavioral, safety, health and/or welfare support needs of the individual (that are distinguished from the support needs of other waiver participants in the same Level of Support Need Matrix cell) and request review by the Individual Budget Oversight Committee prior to submission of the Person Centered Plan and the Individual Budget to the PIHP Access/Utilization Management Department.

If the Individual Budget Oversight Committee determines that the support needs for the participant requesting placement into Level 8 have support needs that fall significantly outside usual and customary support needs, the participant will be included in Level 8 and the Individual Budget developed by the planning team will be approved; however, it is expected based on the experience of other jurisdictions that a maximum of 7% of all current waiver participants may be assigned to Level 8. This treatment of "outliers" is standard practice in the application of resource allocation methodologies.

If a participant's support needs cannot be met through a time limited increase in intensity of services up to the \$135,000 cost limit, a movement from the Non-Residential Level of Support Need Matrix to the Residential Level of Support Need Matrix or has not been approved for placement into Level 8, the participant will be referred to an ICF/MR.

#### Adjustments to the Budget Limits in the Level of Support Need Matrix

The Budget limits in the Level of Support Need Matrix will be adjusted in future years to reflect the service component of the approved capitation rate paid for this waiver. In the event that the service component of the approved capitation rate paid for this waiver is less than or more than the weighted average Level of Support Need Matrix budget limits (plus an allowance for services that are not included in "Base Budget Services"), all budget limits will be uniformly adjusted on a percentage basis to meet the capitation rate. The service component of the approved capitation rate is the total capitation rate less amounts for administration, risk, and services not included in the 1915(c) waiver.

In addition, the overall Level of Support Need Matrix will be periodically evaluated to confirm that the underlying elements upon which it is based continue to be reliable predictors of necessary resources based on assessed support needs. In the event that the levels of need in the Level of Support Need Matrix are modified as a result of this evaluation or based on experience, the State will submit a waiver amendment to CMS before implementation.

**Self Direction**

Participants who self-direct one or more waiver services are subject to the cost limits of the Level of Support Need Matrix in the same manner as other waiver participants. The amount assigned to the Individual and Family Directed Budget will be based on the cost of the Base Budget Services they choose to self-direct. See Appendix E for services that may be self-directed and details and self-direction in the Innovations Waiver.

**Availability of Methodology**

A description of the methodology used by the other jurisdictions to develop the levels of need algorithm is available to CMS upon request. The methodology for determining the Level of Support Need Matrix is available for public review and inspection upon request from Piedmont Behavioral Healthcare.

**Participant Safeguards**

If the planning team determines that a waiver participant has an extended need for an increased intensity of services, (six months) the individual may be authorized a change in living arrangement (from home to a community residential facility) which will move the participant from the Non-Residential Level of Support Need Matrix to the Residential Level of Support Need Matrix or reassessed and if supported by the results of a new SIS assessment, moved to a higher level of support need. If the cost limit in the new living arrangement or the new level of support need will not meet the participant's needs, the participant may seek approval for placement in Level 8.

If the Individual Budget Level Allocation and the Individual Support Plan cannot be developed for Base Budget Services at or below the cost limit, the Support Coordinator will prepare a justification for placement of the participant into Level 8 based on the unique behavioral, safety, health and/or welfare support needs of the Individual ( that are distinguished from the support needs of other waiver participants in the same Level of Support Need Matrix cell) and request review by the Individual Budget Oversight Committee prior to submission of the Individual Support Plan and the Individual Budget Level Allocation to the PIHP Utilization Management Department.

If the Individual Budget Oversight Committee determines that the support needs for the participant requesting placement into Level 8 *have* support needs that fall significantly outside usual and customary support needs, the participant will be included in Level 8 and the Individual Budget Level Allocation developed by the planning team will be approved, however, it is anticipated, based on the results in other jurisdictions that no more than 7% 5 percent of all current waiver participants might be assigned to Level 8. This treatment of individuals who are "outliers" is standard practice in the application of assessment informed resource allocation methodologies for individuals with intellectual or developmental disabilities.

If a participant's support needs cannot be met through a time limited increase in intensity of

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services or a movement from the Non-Residential Level of Support Need Matrix to the Residential Level of Support Need Matrix or the participant has not been approved for placement into Level 8, the participant will be referred to ICF-MR as their care cannot be met within \$135,000 cost limit.

**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*