

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

I. Request Information

- A. The State of **North Carolina** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Waiver Title (*optional*): **NC Innovations**
- C. CMS Waiver Number: **0423.01**
- D. Amendment Number (*Assigned by CMS*):
- E.1 Proposed Effective Date: **October 1, 2011**
- E.2 Approved Effective Date (*CMS Use*):

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This is a request to amend the NC Innovations HCBS Waiver (CMS Control #0423.01), effective October 1, 2011. The NC Innovations waiver provides support for individuals with intellectual and other developmental disabilities and has operated concurrently with a 1915(b) waiver in a five-county service area since April 1, 2005. These waivers include all Medicaid mental health, intellectual/developmental disabilities, and substance abuse services which are delivered through a single prepaid inpatient health plan (PIHP), Piedmont Behavioral HealthCare (PBH). PBH is a local management entity (LME). LMEs are area authorities which, in the State of NC, are responsible for certain management and oversight activities with respect to publicly funded MH/IDD/SA services. Both the 1915(b) and 1915(c) waivers were amended effective April 1, 2010 to prepare for expansion of the program to other geographic areas of the State and the addition of additional LMEs functioning as managed care entities (PIHPs) similar to PBH. This expansion request includes:

Expansion of the PBH service area:

- Effective 10-1-2011 – Alamance and Caswell counties (Alamance Caswell LME)
- Effective 1-1-2012 – Franklin, Granville, Halifax, Vance and Warren counties (Five County LME)
- Effective 4-1-2012 – Orange, Person, Chatham (OPC LME)

Expansion of the service area to include other PIHPs:

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- **1/1/12 Western Highlands: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties.**
- **4/1/12 East Carolina Behavioral Health (ECBH): Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties.**
- **7/1/12 Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond.**
- **7/1/12 Smoky Mountain: Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes Counties.**

Appendix J has been updated to reflect the expansion in years 4 and 5 of the waiver.

Individuals in the expanded coverage areas will be transitioning from the State's CAP-MR/DD Comprehensive and Supports waivers (0662 and 0663).

Other changes requested include:

- Name change from Cardinal Innovations to NC Innovations.
- The PIHPs will not be required to have Murdoch Center, a State operated ICF-MR, conduct level of care evaluations. LOC evaluations may be conducted directly by the PIHP.
- The plan of care function does not have to be contracted to an independent case management entity. Care coordinators (case managers) who develop the plan of care are employees of the PIHP in a department separate and apart from the PIHP's utilization management department which reviews and makes prior authorization decisions on all service requests.
- Public process for involving stakeholders has been updated.

QM performance measures have been changed to reflect the Innovations performance measures in the original waiver and two additional performance measures have been added.

- The Support Needs Matrix which addresses individual budget levels has been updated primarily to reflect changes in terminology and phasing in new waiver participants to Matrix based service plans for the current the geographic area in the original PBH area. Transition language has been added for PIHP's that are transitioning into the NC Innovations waiver
- The Community Guide definition has been updated.

III. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver		Subsection(s)
<input checked="" type="checkbox"/>	Waiver Application	1, 2, 4, 6, and Transition Plan
<input checked="" type="checkbox"/>	Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/>	Appendix B – Participant Access and Eligibility	B-1, B-2, B-3,
<input checked="" type="checkbox"/>	Appendix C – Participant Services	C-2, C-3, C4
<input checked="" type="checkbox"/>	Appendix D – Participant Centered Service Planning and Delivery	D-1
<input checked="" type="checkbox"/>	Appendix E – Participant Direction of Services	E-1
<input type="checkbox"/>	Appendix F – Participant Rights	
<input type="checkbox"/>	Appendix G – Participant Safeguards	
<input type="checkbox"/>	Appendix H – Quality Management Strategy	
<input type="checkbox"/>	Appendix I – Financial Accountability	
<input checked="" type="checkbox"/>	Appendix J – Cost-Neutrality Demonstration	J-1 and J-2

Performance measures in all sections have been modified.

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

<input type="checkbox"/>	Modify target group(s)
<input type="checkbox"/>	Modify Medicaid eligibility
<input type="checkbox"/>	Add/delete services
<input checked="" type="checkbox"/>	Revise service specifications
<input checked="" type="checkbox"/>	Revise provider qualifications
<input checked="" type="checkbox"/>	Increase/decrease number of participants
<input checked="" type="checkbox"/>	Revise cost neutrality demonstration
<input type="checkbox"/>	Add participant-direction of services
<input checked="" type="checkbox"/>	Other (specify):
	The other specific items this amendment request addresses are listed above in I – Purpose of Amendment.

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name: Judy
Last Name: Walton
Title: Program Administrator
Agency: Division of Medical Assistance, North Carolina Department of Health & Human Services (NCDHHS)
Address 1: 2501 Mail Service Center
Address 2:
City: Raleigh
State: NC
Zip Code: 27699-2501
Telephone: 919-855-4265
E-mail: Judy.walton@dhhs.nc.gov
Fax Number: 919-715-4715

- B. If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is: N/A

First Name:	
Last Name:	
Title:	
Agency:	
Address 1:	
Address 2:	
City:	
State:	
Zip Code:	
Telephone:	
E-mail:	
Fax Number:	

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: _____

Date: _____

State Medicaid Director or Designee

First Name: Craigan
Last Name: Gray, MD, MBA, JD
Title: Medicaid Director
Agency: Division of Medical Assistance, NCDHHS
Address 1: 2501 Mail Service Center
Address 2: 1985 Umstead Drive
City: Raleigh
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E-mail:
Fax Number: 919-733-6608

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: July 1, 2011

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 NC Innovations HCBS waiver (CMS Control #0423.01), effective October 1, 2011. The NC Innovations waiver provides support for individuals with intellectual and other developmental disabilities in a five-county service area and operates concurrently with a 1915(b) waiver. All MH/IDD/SA services are delivered through an at-risk prepaid inpatient health plan (PIHP). The primary purpose of the waiver amendment is to expand the waiver to additional counties and PIHPs.:

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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Effective Date	October 1, 2011

Application: 1

1. Request Information

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

B. Waiver Title (optional): **NC Innovations Waiver**

C. Type of Request (select only one):

<input type="checkbox"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="checkbox"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input type="checkbox"/>	Renewal (5 Years) of Waiver #	0423.01	
<input checked="" type="checkbox"/>	Amendment to Waiver #	4	

D. Type of Waiver (select only one):

<input type="checkbox"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="checkbox"/>	Regular Waiver, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: **October 1, 2011**

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

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="checkbox"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="checkbox"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="checkbox"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="checkbox"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

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<input checked="" type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I	
<input checked="" type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>	
<p>NC Innovations operates concurrently with the North Carolina (NC) MH/DD/SAS 1915(b) Health Plan, waiver number NC 02.RO1, which was renewed effective April 1, 2009 through March 31, 2011.</p>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input checked="" type="checkbox"/>
		§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/>
		§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.</i>	
<input type="checkbox"/>	A program authorized under §1915(j) of the Act	
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>	
<input type="checkbox"/>	Not applicable	

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2. Brief Waiver Description

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

The NC Innovations 1915(c) Home and Community-Based Services waiver (HCBS) program for individuals with intellectual disabilities and other developmental disabilities operates concurrently with the 1915(b) NC mental health/developmentally disabled/substance abuse services (MH/DD/SAS) waiver. Waiver services and supports are available to individuals who, for the purposes of Medicaid eligibility, are residents of counties served by the Prepaid Inpatient Health Plan (PIHP). MH/DD/SAS local management entities (LMEs) function as PIHPs through which all MH, SA and DD services are authorized for Medicaid beneficiaries in the operating areas. The NC Innovations waiver is currently authorized in a five-county area and services are delivered through the PBH PIHP. The service area will be expanding to a larger geographic area upon approval by CMS of this amendment.

Purpose: The NC Innovations waiver is designed to provide an array of community-based services and supports that promote choice, control and community membership. These services provide a community-based alternative to institutional care for persons who require an intermediate care facility – mental retardation (ICF-MR) level of care.

Goals of the NC Innovations waiver:

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

Objectives in the NC Innovations waiver include:

- (1) Enhancing the focus on person centered planning and aligning services and supports with person centered plans
- (2) Reforming residential service to facilitate smaller community congregate living situations
- (3) Facilitating living and working in the most integrated setting
- (4) Improving outcome-based quality assurance systems

Service Delivery Methods: All NC Innovations waiver services are authorized through the annual Individual support plan (ISP), which is developed using person centered planning methods. Waiver

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participants may select any qualified network provider to furnish authorized services. NC Innovations offers participant direction to participants who elect to direct their own services. Orientation to participant direction is offered to all waiver participants upon entrance to the waiver and annually thereafter during ISP development. Participants in the waiver have a care coordinator who assists them in developing an ISP, ensuring the participant's health and safety needs are met, that services and supports are provided in the most integrated setting, and that the participant is satisfied with the services and supports they are receiving. Services are delivered through a network of licensed and contracted community-based service providers that are charged with implementing waiver participants' ISPs by providing services and supports that enhance the participant's quality of life as defined by the participant. Minors will be considered as a family of one for financial eligibility. National accreditation is required of providers of waiver services and a transition period is allowed for new providers.

This waiver contains a cost limit of \$135,000.

3. Components of the Waiver Request

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

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the person centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- | | |
|----------------------------------|--|
| <input checked="" type="radio"/> | The waiver provides for participant direction of services. <i>Appendix E is required.</i> |
| <input type="radio"/> | Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i> |

- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

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

4. Waiver(s) Requested

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

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

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

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

<input checked="" type="radio"/>	Yes (<i>complete remainder of item</i>)
<input type="radio"/>	No

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

<input checked="" type="radio"/>	<p>Geographic Limitation. A waiver of state wideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p> <p>The NC Innovations waiver currently serves individuals who are legal residents, for the purpose of Medicaid eligibility, of the following counties: Cabarrus, Davidson, Rowan, Stanly and Union counties. The waiver is being modified to expand the service area to the following counties: Effective 10-1-2011 – Alamance and Caswell counties (Alamance Caswell LME) Effective 1-1-2012 – Franklin, Granville, Halifax, Vance and Warren counties (Five County LME); Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties (Western Highlands LME) Effective 4-1-2012 – Orange, Person, Chatham (OPC LME); Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties (East Carolina Behavioral Health (ECBH) LME) Effective 7-1-12: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties (Sandhills LME); Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilke Counties (Smoky Mountain LME)</p>
<input checked="" type="radio"/>	<p>Limited Implementation of Participant-Direction. A waiver of state wideness is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere</p>

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in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area.*

Both models of individual and family directed supports (Employer of Record and Agency With Choice) will be available in the PBH area and in the PBH expansion counties. In the other PIHP'S, the Agency With Choice Model will be initially offered. The Employer of Record Model will be available in 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 documents and a plan that demonstrates that contracted Community Guide Agencies have or will be trained by the proposed implementation date. DMA will approve implementation plans prior to implementation date. The Intra Departmental Monitoring Team will provide oversight in the implementation of Individual and Family Directed Supports.

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,

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2. Given the choice of either institutional or home and community-based waiver services.

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

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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- C. Room and Board.** In accordance with 42 CFR §441.310(a) (2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The processes described below have continued since the April 1, 2010 amendment was submitted regarding the plan for statewide expansion of managed care for Medicaid covered MH/DD/SA services through local management entities (LMEs) functioning as prepaid inpatient health plans (PIHPs). Updates are provided and feedback obtained through all of the venues listed below.

The Board of Directors of the three Local Management Entities that govern the 10 expansion counties met with PIHP management staff and requested to become partners in the NC Innovations Health Plan. The State has increased its commitment to expansion of (b)/(c) waiver programs through House Bill 916 which was signed into law by the Governor on June 23, 2011 and requires statewide implementation of managed MH/DD/SAS care by July 1, 2013. The focus of stakeholder forums has begun with the first area of transition; Alamance and Caswell counties. Stakeholder meetings have been held with participants, providers and

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community partners to discuss the waiver expansion and transition issues in these two counties. Future meetings are planned with the remaining eight counties. The same processes as were used in the 2005 implementation will be employed in this implementation to ensure stakeholder input and a seamless transition.

A public process with significant opportunity for public comment by individuals of all races and ethnicities was utilized in designing the original framework for the Piedmont pilot program. A series of local forums to obtain input from all stakeholders was conducted and a consumer family advisory committee was established to ensure consumer input to both the planning process and the ongoing operation of the program. A website was also developed which provided information about Piedmont's plan and a feedback link for public comments.

Since the waiver was implemented in April 2005, the PBH PIHP has maintained open communication with consumers, providers and other stakeholders through consumer and provider satisfaction surveys, grievance tracking and analysis, and active consumer affairs and community relations offices. Outreach, cultural sensitivity and coordination with community resources for the best possible consumer outcomes are the central focus of the consumer affairs and relations offices. As described in detail in Section C of the concurrent 1915(b) waiver, Monitoring Results, stakeholder feedback from the Piedmont pilot was incorporated for system improvement in the PIHP expansion.

For the statewide expansion, the following public process has occurred:

- Session Law 2009-451 authorizes the Department of Health and Human Services (DHHS) to “carry out pilot programs for prepaid health plans, contracting for services, managed care plans, or community-based services programs in accordance with plans approved by the United States Department of Health and Human Services or when the Department determines that such a waiver will result in a reduction in the total Medicaid costs for the recipient.” Based on this authority, the DHHS Secretary instructed the Department to prepare for an expansion of the concurrent Piedmont 1915(b)/(c) waivers to other areas of the State. The Secretary provided information on the plan to the joint legislative oversight committee on mental health, developmental disabilities and substance abuse services during regularly scheduled meetings in September and October of 2009.
- The Department facilitates meetings quarterly with the directors of the LMEs. The Department's division directors of Medical Assistance and Division of Mental Health (DMH)/DD/SAS presented and discussed the expansion plan at the October 21, 2009 meeting. Department officials will continue to provide updates and accept input, comments and questions at these meetings.
- The Division of MH/DD/SAS sponsors an External Advisory Team, a stakeholder group with representation from LMEs, providers, professional organizations and consumers, which advises the Division on statutes, rules and policies. DMA and DMH directors and officials attend monthly meetings and will be discussing and receiving comments on the waivers at future meetings.
- The State Consumer Family Advisory Committee (SCFAC), which communicates information to the local Consumer Family Advisory Committee, is a primary means of communicating with consumers. The committee meets monthly and the DMH/DD/SAS director provides updates on issues that impact and are of interest to consumers. The

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waiver expansion plan has been discussed on an ongoing basis at these meetings.

- **DMA will notify providers of the planned changes via monthly Medicaid Bulletins. The first article about the expansion will be in the December bulletin and subsequent bulletins will contain updates on progress with the waiver, entities selected for expansion and implementation of the new processes and procedures for service authorization and delivery.**
- **DMA announced the expansion at the November NC Finance and Reimbursement Organization (NC-FARO) conference. NC-FARO is a non-profit organization that supports all stakeholders in the public MH/DD/SA service sector.**
- **The NC Council of Community Programs is a non-profit organization that supports member LMEs in areas such as policy analysis, educational programs and technical assistance. The DMA and DMH directors provide updates at monthly directors' forums and they will discuss the waiver expansion at the December 2009 conference.**
- **The county departments of social services assist the State in the local administration of the Medicaid program and are primary contacts for many Medicaid recipients. DMA will provide information regularly on the waiver expansion to the DSS through formal written communications. In addition, DMA has a team of Medicaid Program Representatives (MPRs) who consult with and provide technical assistance on program changes to their respective counties on a regular basis.**
- **DHHS has formed a core work group with representatives from DMA and DMH who are working with the State's contracted consultant to develop expertise on waiver development, plan selection criteria and readiness for transition to managed care operations. The work group will be responsible for training and providing information to their colleagues in both agencies to facilitate the transition to managed care. DMH has designated a leadership team for the project and is providing regular updates to staff via their website.**

The Eastern Band of Cherokee is the only federally recognized tribe with tribal lands in North Carolina. The State formally notified tribal leaders of the plan to expand the waiver in writing on June 30, 2011 and discussed the expansion via conference call in detail on July 6, 2011. In addition, the State had a conference call with tribal leaders on April 20, 2011 to discuss and solicit input on the expansion.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003).

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Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

First Name:	Judy
Last Name:	Walton
Title:	Waiver Development Chief
Agency:	Division of Medical Assistance, NCDHHS
Address 1:	2501 Mail Service Center
Address 2:	
City:	Raleigh
State:	NC
Zip Code:	27699-2501
Telephone:	919-855-4265
E-mail:	Judy.walton@dhhs.nc.gov
Fax Number:	919-715-1255

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

First Name:	
Last Name:	
Title:	
Agency:	
Address 1:	
Address 2:	
City:	
State:	
Zip Code:	
Telephone:	
E-mail:	
Fax Number:	

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8. Authorizing Signature

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

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

Signature: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Craigan
Last Name:	Gray, MD, MBA, JD
Title:	Medicaid Director
Agency:	Division of Medical Assistance, NCDHHS
Address 1:	2501 Mail Service Center
Address 2:	1985 Umstead Drive
City:	Raleigh
State:	NC
Zip Code:	27699-2501
Telephone:	919-855-4101
E-mail:	
Fax Number:	919-733-6608

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The State will ensure successful transition to the waiver program through the following activities: The LMEs will have monthly intradepartmental meetings with the State which are led by the Division of Medical Assistance and have representation from the Division of MH/DD/SAS. Each LME will have an implementation plan which will be discussed at each meeting, and the plans will be updated and submitted to DMA prior to each IMT meeting. Each LME functioning as a new PIHP will undergo on-site readiness reviews 120 days and 60 days prior to planned implementation; the on-site reviews are conducted by DMA and DMH staff and DMA's contractor, Mercer Government Services. The LME is furnished with a report of findings and issues that must be addressed/resolved prior to implementation. The LMEs are approved for waiver participation on the condition that the findings from the readiness reviews and the IMT meetings confirm that the LME has successfully

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transitioned to a managed care entity.

The PBH Innovations waiver will serve these counties according to the following phase in schedule in years four and five of the waiver:

-October 1, 2011, PBH will expand their managed care operations into Alamance and Caswell Counties.

-January 1, 2012, PBH will expand their managed care operations into the Five-County LME consisting of Franklin, Granville, Halifax, Vance, and Warren Counties.

-January 1, 2012, Western Highlands will consist of Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties.

-April 1, 2012, PBH will expand their managed care operations into the Orange, Person, and Chatham Counties.

-April 1, 2012 East Carolina Behavioral Health (ECBH) will have Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties.

-July 1, 2012 Sandhills will have Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties.

-July 1, 2012 Smoky Mountain will have Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes Counties

The waiver slots will be increased as the waiver expands to the new areas outlined above. Waiver year four will begin with 688 slots (including 19 reserved slots) for the PBH area. The waiver will expand to 826 slots (including 22 reserved slots) as of October 1, 2011 with the addition of Alamance and Caswell Counties and further expand to 2081 slots (including 68 reserved slots) as of January 1, 2012 with the addition of the 5-County LME and Western Highlands. Waiver year five will begin with 3216 slots (including 101 reserved slots) as of April 1, 2012 including OPC and ECBH and 4461 slots (including 147 reserved slots) as of July 1, 2012 including Sandhills and Smoky Mountain.

The waiver will be amended at a later date to include the remaining 35 counties. These counties will be transitioned to the waiver program using the same processes described in the previous paragraph. The remaining 35 counties and their respective LMEs are as follows:

- (It is anticipated that Sandhills will expand operations to cover Guilford County which will be merged by January 1, 2013)
- Pathways, consisting of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin Counties, will be operational by January 1, 2013
- Eastpointe, consisting of Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson Counties, will be operational by January 1, 2013
- Mecklenburg LME will be operational by January 1, 2013
- The Durham Center, consisting of Durham, Cumberland, Johnston, and possibly Wake Counties will be operational by January 1, 2013
- CenterPoint, consisting of Davie, Forsyth, Rockingham, and Stokes Counties, will be operational

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by January 1, 2013

- Southeastern Center (ECCS) consisting of Brunswick, New Hanover, Pender, Onslow, and Carteret Counties, will be operational by January 1, 2013

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. Likewise, 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. The NC SNAP will be used as the standardized assessment until it is replaced by the Supports Intensity Scale per the transition plan. The NC Innovations waiver includes services that crosswalk to the CAP-MR/DD waiver.

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

- maintain Home and Community based character and meet all other waiver requirements defined in Appendix C:2.
- currently provide Residential Supports under the CAP-MR/DD waiver
- are qualified under the PIHP network which ensures that they meet the service specific provider qualifications and
- choose to join the PIHP network

All NC Innovations waiver services have transportation embedded in the rate for the service to allow the participant to access the waiver services. Community Networking also covers transportation for inclusive activities in the community.

The service definition for Supported Employment has been divided to clearly define the activities that will transition from Long Term Vocational Supports under the CAP-MR/DD waiver to Supported Employment under the NC Innovations waiver.

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Appendix A: Waiver Administration and Operation

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

<input checked="" type="checkbox"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one; do not complete Item A-2</i>):	
<input checked="" type="checkbox"/>	The Medical Assistance Unit (<i>name of unit</i>):	The Division of Medical Assistance, NC Department of Health and Human Services
<input type="checkbox"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. <i>Complete item A-2</i>	
<input type="checkbox"/>	The waiver is operated by _____ a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-3.</i>	

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

<input checked="" type="checkbox"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
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	<p>NC Innovations operates concurrently with network health plans using 1915(b) waiver authority to provide for the delivery of all MH/DD/SA services, including NC Innovations waiver services, to Medicaid beneficiaries in the service areas. All Medicaid MH/DD/SA services, including NC Innovations waiver services, are authorized by and provided through the plans in accordance with the risk contract between the DMA and the plans. The contracts require the plans to conduct the following operational and administrative activities: all utilization management and prior approval activities, provider network credentialing and enrollment and provider reimbursement. DMA also contracts with an agency to function as the External Quality Review Organization (EQRO) for the concurrent waivers.</p> <p>The DMA contracts with a vendor to conduct rate setting.</p> <p>DMA has sole responsibility for operation of the Innovations waiver.</p>
<input type="checkbox"/>	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

3. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a MOU or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

N/A

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

<input type="checkbox"/>	<p>Local/regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or MOU between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or MOU is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<p>Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>

The local management entities (LMEs) are regional non-governmental, non-state area

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authority which have, by state statute, certain oversight and coordination responsibilities for publicly funded MH/DD/SA services.

The NC General Assembly, in session law 2001-437, designated the local mental health authorities (LMEs) as the locus of coordination for the provision of all publicly funded MH/DD/SAS services. LMEs are the local lead agencies for the day-to-day operations of the waiver in the counties they serve. LMEs assure that the policies and procedures for all the programs in the public MH/DD/SAS system are followed, including waiver services.

The LMEs are responsible for the administration and operation of 1915 (c) waiver programs in their area. They must assure that the policies and procedures for the waiver and all programs in the public MH/DD/SA service system are followed. They are responsible for the health, safety and welfare of participants receiving services, for assuring integrity and improvement of the provision of services and supports with the ISP.

LMEs have the following responsibilities:

- Serve as the single portal for HCBS services eligibility
- Provide information to waiver participants about their rights, protections.
- Assure family/recipient awareness and choice for all available waiver services and responsibilities, including the right to change providers
- Resolve issues related to participants' health and safety or service delivery that are unresolved by the care coordinator
- Conduct annual health and safety reviews for unlicensed Alternative Family Living (AFL) residences
- Manage appeals for levels of care
- Contract with network service providers and pay claims
- Maintain service provider lists, recruit providers to address unmet needs, provide training and technical assistance to provider agencies contracted to provide services in the catchment area
- Assure family/recipient awareness and choice for all available waiver services
- Utilize paid claims as warranted by specific situations as needed with follow up on any discrepancies noted
- Provide or arrange for 24/7/365 crisis response system.
- Conduct ongoing monitoring of contracted providers based on a standardized monitoring protocol and scheduled based on a confidence level calculation
- Provide technical assistance to providers
- Oversee and provide follow-up to ensure implementation of plans of correction
- Implement a quality improvement system that includes an incident review committee, external CFAC, quality improvement committee and client rights committee
- Receive, track and respond to participant complaints and appeals
- Receive, track and respond to incident reports from providers; prepare incident trend reports for DMH/DD/SAS
- Assess community service needs and develop provider capacity

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- **Monitor and oversee care coordinators working with individuals leaving state facilities to ensure they are monitoring health and safety and implementation of the ISP**

Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

The DMA, along with the DMH/DD/SAS within the DHHS are responsible for assessing the performance of the PIHPs in conducting operational and administrative functions.

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

This waiver operates concurrently with the NC MH/IDD/SAS 1915(b) Health Plan waiver. Performance expectations and methods of evaluation and oversight by the State, which are summarized below, are delineated in the risk contract between the State Medicaid agency and PIHPs.

Oversight of the concurrent waivers is performed by an Intra-Departmental Monitoring Team (IMT) with representation from all divisions within the DHHS involved in the operation of the 1915(b)/(c) waivers with DMA leading the team. Each PIHP must report to the IMT on internal quality assurance/improvement activities such as consumer and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect service delivery. The team provides feedback and implements corrective action plans as needed. The IMT also conducts an annual on-site review of each PIHP's operations. The team reviews overall PIHP operations, including utilization and care management, clinical direction, executive management, claims processing, financial management, information systems and reporting. A written report of findings is generated and a plan of correction for deficiencies is implemented if needed. Progress with the plan of correction is tracked by the IMT quarterly.

DMA requires quarterly and annual statistical reporting on service utilization and access to care. DMA also requires quarterly complaints and grievance reports and takes corrective action as needed.

DMA contracts with an EQRO, as required by federal managed care regulations, to evaluate PIHPs compliance with the quality assurance standards outlined in the risk contract. The review is conducted once during each five-year 1915(b) waiver period and consists of both a desktop review and an on-site visit.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves

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policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medicaid provider agreements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Participant service plans	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management functions	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Enroll all willing and qualified providers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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Quality Management: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State’s quality management strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	<i>The PIHP implements and reports on the performance measures as required throughout this application regarding waiver assurances and sub-assurances in the areas of level of care, qualified provider, service plan development, implementation and monitoring, consumer health and welfare and financial accountability.</i>		
Data Source: Reports to State Medicaid Agency from PIHP	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	The PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		<i>As specified for each performance measure in this document.</i>	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify)
	<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other (Specify):	
	As specified for each performance measure in this document.		

Performance Measure:	<i>THE PIHP implements corrective action plans as required and approved by DMA for problems/deficiencies identified through performance measure reporting, on-site reviews, record reviews, EQRO and independent assessment findings and other oversight activities.</i>		
Data Source: Reports to State Medicaid Agency from PIHP	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PBH	<input checked="" type="checkbox"/> Other (Specify):	
		As problems are detected and corrective action plans implemented.	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>DMA conducts monitoring of PBH corrective action plans as specified below.</i>
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Data Source Reports to State Medicaid Agency by PIHP	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		As issues requiring correction are identified.	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>DMA tracks waiver participation through reporting by PBH on new enrollees and consumers transferring in from other waivers.</i>		
Data Source Reports from PIHP to State Medicaid Agency	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify): THE PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and	Frequency of data aggregation and	Method of Aggregation

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	analysis (check each that applies): <input checked="" type="checkbox"/> State Medicaid Agency <input type="checkbox"/> Operating Agency <input type="checkbox"/> Case Management Agency <input type="checkbox"/> Other (Specify):	analysis (check each that applies): <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other (Specify):	Reporting (check each that applies): <input type="checkbox"/> Narrative Report <input type="checkbox"/> Data Compilation <input checked="" type="checkbox"/> Other (Specify): <i>The state will maintain running report to track unduplicated users during the waiver year.</i>
--	--	--	--

Performance Measure:	<i>DMA reviews the PIHP Innovations provider network for adequate capacity and choice as specified below.</i>		
Data Source: PIHP produces network provider report showing subset of NC Innovations providers for State Medicaid Agency	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify): THE PIHP	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other (Specify):	
		<i>Interim reports may be required based on concerns about adequacy/choice.</i>	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	

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		<input type="checkbox"/> <i>Other (Specify):</i>	
--	--	--	--

Performance Measure:	<i>THE PIHP reviews a sample of NC Innovations consumer records, including encounter data, to determine compliance with waiver assurances and reports to DMA as specified below.</i>		
Data Source: Report of record review findings by PIHP to State Medicaid Agency	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Representative Sample With confidence interval of 95%</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other (Specify): PBH</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
		<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		<i>Semi-annually</i>	<input checked="" type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other (Specify):</i>
	<input type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		<i>Semi-annually</i>	

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

Please note that the performance measures/monitoring activities, outlined above, regarding the authority of the State Medicaid Agency are meant to assure that all operational and administrative activities delegated to PBH, as described in Appendix A-7, are carried out appropriately.

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B. Methods for Remediation

i. Describe the State’s strategy for addressing individual problems as they are discovered.

THE PIHP will address and correct problems identified on a case-by-case basis in accordance with its contract with the DMA. The DMA may require a corrective action plan for the problems identified. The DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team. PBH will notify the State immediately of any situation in which the health and safety of a consumer is jeopardized.

ii. Remediation Data Aggregation

<i>Remediation-related Data Aggregation and Analysis (including trend identification)</i>	<i>Responsible party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>	<i>Method of aggregation reporting (check each that applies):</i>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other (Specify):	

iii. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

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Appendix B: Participant Access and Eligibility

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

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

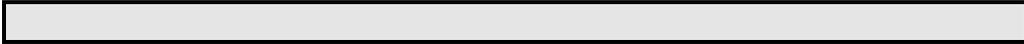
SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="checkbox"/>	Aged or Disabled or Both (<i>select one</i>)			
<input type="checkbox"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Disabled (Physical) (under age 65)			
	<input type="checkbox"/> Disabled (Other) (under age 65)			
<input type="checkbox"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation or Developmental Disability or Both (<i>check each that applies</i>)			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/> Developmental Disability	Birth		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Mental Retardation	Birth		<input checked="" type="checkbox"/>
<input type="checkbox"/>	Mental Illness (<i>check each that applies</i>)			
	<input type="checkbox"/> Mental Illness (age 18 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Serious Emotional Disturbance (under age 18)			

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

The Cardinal Innovations waiver targets individuals who meet the ICF-MR eligibility criteria defined in Division of Medical Assistance Clinical Coverage Policy No: 8E. The specific criteria can be found in Appendix B-6d of this application.

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

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

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

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Appendix B-2: Individual Cost Limit

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

<input type="checkbox"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>	
<input checked="" type="checkbox"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):	
<input type="checkbox"/>		%, a level higher than 100% of the institutional average
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	
<input type="checkbox"/>	\$135,000. This is the same amount set by the Legislature for the Comprehensive waiver (NC.0662) and it is approximately 112% of institutional cost.	
<input type="checkbox"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>	
<input type="checkbox"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>	
The cost limit specified by the State is (<i>select one</i>):		
<input type="checkbox"/>	The following dollar amount: \$	
The dollar amount (<i>select one</i>):		
<input type="checkbox"/>	Is adjusted each year that the waiver is in effect by applying the following formula:	
<input type="checkbox"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	
<input type="checkbox"/>	The following percentage that is less than 100% of the institutional average:	
<input type="checkbox"/>	Other – <i>Specify</i> :	

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

Individuals may apply for the Innovations waiver by contacting the PIHP Access Center in his or her county. The intake/screening process is intended to be the preliminary determination of an individual's potential eligibility for services based on the eligibility criteria and need for waiver services. The screening process consists of a comprehensive clinical review including the administration of the Supports Intensity Scale (SIS) and the NC Innovations Risk/Support Needs Assessment to determine whether the waiver can meet the individual's needs. If health and/or safety risks are identified the PIHP clinical director (M.D. or PhD) will review the assessments and make a determination as to whether the individual's needs can be met by the waiver up to the \$135,000 cost limit. Written notice of the outcome of this assessment will be provided to the individual.

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

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	NA
<input checked="" type="checkbox"/>	Other safeguard(s) (<i>specify</i>):
	Participants whose support needs exceed the cost limitation of the NC Innovations waiver will be offered the option of ICF/MR facility placement.

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Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	625
Year 2	635
Year 3	670
Year 4 (renewal only)	2081
Year 5 (renewal only)	4461

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

<input checked="" type="checkbox"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="checkbox"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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

<input type="radio"/>	Not applicable. The state does not reserve capacity.																	
<input checked="" type="checkbox"/>	<p>The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:</p> <p>Capacity is reserved for the following purposes:</p> <p>Transition of individuals from CAP-Children when the participant ages out of the waiver; and from CAP-MR/DD (#0662 and #0663) when a participant relocates within the State. The reserve figure is based on historical numbers of participants that have transitioned during the past six years and projected per capita growth.</p> <p>Reserved capacity for emergency needs. The reserve figure is based on historical numbers of participants that have had emergency needs during the past three years and projected per capita growth.</p> <p>Money Follows the Person (MFP) – For participants who meet the criteria for Money Follows the Person and choose to receive home and community-based services. North Carolina will be offering services within the community with the Money Follows the Person demonstration grant for 80 participants for the duration of this waiver. The PBH service area is being added to the MFP program.</p> <p>Community Transition for institutionalized children age 17 and younger – Provide opportunity for children who currently reside at a state developmental center or other ICF-MRs, the option to receive home and community-based services. These participants do not necessarily meet the criteria set forth for the MFP Demonstration grant.</p> <p>Military Transfers: Reserved capacity for participants who were on a comparable 1915 (c) waiver in another state whose family was transferred to North Carolina for military service.</p> <p>The capacity that the State reserves in each waiver year is specified in the following table:</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">Table B-3-c</th> </tr> <tr> <th rowspan="2" style="width: 30%;"></th> <th colspan="2" style="text-align: center;">Purpose:</th> </tr> <tr> <th style="width: 35%; text-align: center;">Reserved to accommodate transition between waivers CAP-C and CAP-MR/DD</th> <th style="width: 35%; text-align: center;">Reserved to accommodate emergencies</th> </tr> <tr> <th style="text-align: center;">Waiver Year</th> <th style="text-align: center;">Capacity Reserved</th> <th style="text-align: center;">Capacity Reserved</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Year 1</td> <td style="text-align: center;">10</td> <td style="text-align: center;">10</td> </tr> <tr> <td style="text-align: center;">Year 2</td> <td style="text-align: center;">10</td> <td style="text-align: center;">10</td> </tr> </tbody> </table>	Table B-3-c				Purpose:		Reserved to accommodate transition between waivers CAP-C and CAP-MR/DD	Reserved to accommodate emergencies	Waiver Year	Capacity Reserved	Capacity Reserved	Year 1	10	10	Year 2	10	10
Table B-3-c																		
	Purpose:																	
	Reserved to accommodate transition between waivers CAP-C and CAP-MR/DD	Reserved to accommodate emergencies																
Waiver Year	Capacity Reserved	Capacity Reserved																
Year 1	10	10																
Year 2	10	10																

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Year 3	5	10
Year 4 (renewal only)	37	18
Year 5 (renewal only)	82	18
Table B-3-c		
Waiver Year	Purpose:	Purpose:
	Money Follows the Person	De-institutionalization
	Capacity Reserved	Capacity Reserved
Year 1	0	2
Year 2	0	2
Year 3	2	2
Year 4 (renewal only)	10	6
Year 5 (renewal only)	26	14
Table B-3-c		
Waiver Year	Purpose:	Purpose:
	Military Transfers	
	Capacity Reserved	Capacity Reserved
Year 1	0	
Year 2	0	
Year 3	0	
Year 4 (renewal only)	2	
Year 5 (renewal only)	7	

d. Allocation of Waiver Capacity. Select one:

<input checked="" type="checkbox"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="checkbox"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

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

Screening for Potential Waiver Eligibility

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

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

Reserved Capacity

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

Reserved capacity for emergency needs

Individuals who present with emergency needs are offered entrance to the waiver ahead of other individuals to the extent that reserved capacity is available. A clinical team, inclusive of at least one of the following: Medical Director (psychiatrist) or the DD Clinical Director and a minimum of one developmental disability specialist, assesses the emergency situation. A person is considered to have emergency needs when the individual meets the following eligibility criteria and no other service systems can meet the identified need.

The individual is at significant, imminent risk of serious harm which is documented by a professional and meets one or more of the following criteria:

- 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 custody of the agency
- The individual requires protection from confirmed abuse, neglect or exploitation as documented by the Department of Social Services

Reserved capacity for movement between waivers

Transition of individuals from CAP-C when the participant ages out of the waiver and meets, but does not exceed, the eligibility criteria for this waiver. Transition of individuals from CAP-MR/DD when participants move into one of the counties covered by the NC Innovations waiver, which results in a

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change in the participant's Medicaid county of eligibility. The reserve figure is based on historical numbers of participants that have transitioned during the past three years and projected per capita growth. If reserved capacity is not available, individuals who are transitioning will be prioritized for entrance to the waiver based on non-reserved criteria.

Reserved capacity for Money Follows the Person (MFP)

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

Reserved capacity for Community Transition for Institutionalized Children ages 0-17:

When reserved capacity is available, 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. If reserved capacity is not available, individuals will be prioritized for entrance to the waiver based on non-reserved criteria

Military Transfers:

Reserved capacity for participants who were on a comparable 1915 (c) waiver in another state whose family was transferred to North Carolina for military service.

Non Reserved Capacity:

Potentially eligible participants will be allocated waiver funding based on their date of application and their placement in priority ranking resulting from the equitable distribution of waiver funding on a per capita basis geographically among the sub divisions of the waiver region. If a specific sub division has no referrals, the unused waiver slots will be reallocated among remaining sub divisions of the NC Innovations region based on the per capita equitable distribution of the individuals waiting.

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

a-2. Miller Trust State.

<input type="radio"/>	Yes
<input checked="" type="radio"/>	No

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

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="checkbox"/>	100% of the Federal poverty level (FPL)
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (Balanced Budget Act [BBA] working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (Ticket to Work and Work Incentives Improvement Act [TWWIA] Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (Tax Equity and Fiscal Responsibility Act [TEFRA] 134 eligibility group as provided in §1902(e)(3) of the Act)
<input checked="" type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR 435.320, 435.322 and 435.324)
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
	42 CFR 435.135 (pass-along)
	Individuals under 42 CFR 435.115(e)(1) Title IV-E adoptive children
	Individuals under 42 CFR 435.115(e)(2) Title IV-E foster children

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

<input checked="" type="checkbox"/>		No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input type="checkbox"/>		Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="checkbox"/>		All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input type="checkbox"/>		Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):
<input type="checkbox"/>		A special income level equal to (select one):
<input type="checkbox"/>		300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)
<input type="checkbox"/>	\$	which is lower than 300%
<input type="checkbox"/>		Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>		Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input type="checkbox"/>		Medically needy without spend down in 209(b) states (42 CFR §435.330)
<input type="checkbox"/>		Aged and disabled individuals who have income at: (<i>select one</i>)
<input type="checkbox"/>		100% of FPL
<input type="checkbox"/>	%	of FPL, which is lower than 100%
<input type="checkbox"/>		Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) <i>specify</i> :
<input type="checkbox"/>		

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) <u>and</u> Item B-5-d.
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (Complete Item B-5-b-1) or under §435.735 (209b State) (Complete Item B-5-c-1). Do not complete Item B-5-d.
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>):
<input type="radio"/>	SSI standard
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300%.
<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (specify):

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<input type="radio"/>	The following dollar amount:	\$ <input style="width: 100px;" type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ <input style="width: 100px;" type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (select one):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	\$ <input style="width: 100px;" type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
<input type="radio"/>	The State does not establish reasonable limits.	

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<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>):	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>		% of the FBR, which is less than 300%
<input type="radio"/>		\$ which is less than 300%?
<input type="radio"/>		% of the Federal poverty level
<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):	
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (<i>specify</i>):	
ii. Allowance for the spouse only (<i>select one</i>):		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
Specify the amount of the allowance:		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	

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<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (<i>select one</i>):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: \$ <input style="width: 50px;" type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
<input type="radio"/>	The amount is determined using the following formula: <input style="width: 100%; height: 20px;" type="text"/>	
<input type="radio"/>	Other (<i>specify</i>): <input style="width: 100%; height: 20px;" type="text"/>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input style="width: 100%; height: 20px;" type="text"/>	

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)	
<input type="radio"/>	The following standard under 42 CFR §435.121: <input style="width: 100%; height: 20px;" type="text"/>	
<input type="radio"/>	Optional State supplement standard	

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<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% of the FBR, which is less than 300%
<input type="radio"/>	\$ which is less than 300% of the FBR
<input type="radio"/>	% of the Federal poverty level
<input type="radio"/>	Other (specify):
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:
ii. Allowance for the spouse only (<i>select one</i>):	
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
Specify the amount of the allowance:	
<input type="radio"/>	The following standard under 42 CFR §435.121:
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iii. Allowance for the family (<i>select one</i>):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:

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<input type="radio"/>	Other (specify):
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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

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

i. Allowance for the personal needs of the waiver participant (<i>select one</i>):	
<input type="radio"/>	SSI Standard
<input type="radio"/>	Optional State Supplement standard
<input type="radio"/>	Medically Needy Income Standard
<input type="radio"/>	The special income level for institutionalized persons
<input type="radio"/>	% of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:
<input type="radio"/>	Other (<i>specify</i>):
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one:</i>	

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<input type="radio"/>	Allowance is the same
<input type="radio"/>	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges.	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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Appendix B-6: Evaluation/Reevaluation of Level of Care

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

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

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is (<i>insert number</i>):
	1
ii.	Frequency of services. The State requires (<i>select one</i>):
<input checked="" type="radio"/>	The provision of waiver services at least monthly
<input type="radio"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
	The initial level of care is determined by clinical staff at THE PIHP; reevaluations are conducted by THE PIHP care coordinator.
<input type="radio"/>	Other (<i>specify</i>):

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

Persons performing initial evaluations of level of care for waiver participants are Psychologists, Psychological Associates or Physicians as appropriate based on the disability of the participant. All professionals must hold current licensure in the state of North Carolina.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are

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available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The NC Innovations waiver targets individuals who meet the ICF-MR eligibility criteria defined in The Division of Medical Assistance Clinical Coverage Policy No: 8E. The NC Innovations waiver utilizes the following ICF-MR criteria to evaluate and reevaluate waiver eligibility:

The waiver participant requires 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. 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. Persons with closely related conditions refers to individuals who have a severe chronic disability that meets ALL of the following conditions and is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, that is closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to mentally retarded persons:

- 1. It is manifested before the person reaches age 22**
- 2. It is likely to continue indefinitely**
- 3. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self care (ability to take care of basic life needs for food, hygiene and appearance)**
 - b. Understanding and use of language (ability to both understand others and to express ideas or information to others) and to express language (ability to both understand others and to express ideas or information to others either verbally or nonverbally)**
 - c. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)**
 - d. Mobility (ambulatory, semi-ambulatory, non-ambulatory)**
 - e. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect oneself)**
 - f. Capacity for independent living (age appropriate ability to live without extraordinary assistance)****

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

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

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- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Initial Level of Care Criteria:

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

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

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

Re-evaluation of LOC:

Re-evaluation of LOC is completed annually during or up to 30 days prior to the birth month of the participant. Re-evaluations are completed by qualified professionals who are THE PIHP care coordinators employed or contracted with THE PIHP, using the annual recommendation for LOC, a component of the ISP.

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

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

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

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<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input type="radio"/>	Every twelve months
<input checked="" type="radio"/>	Other schedule (<i>specify</i>):
Reevaluations of the level of care take place at least annually for each waiver participant according to the following schedule: during or up to 30 days prior to the birth month of the waiver participant. If there is a change in the participant's condition, a re-evaluation is performed within 30-days of the identification of the change in condition.	

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

<input type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input checked="" type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

Annual re-evaluations will be completed by a qualified professional who is a care coordinator within The PIHP unit or a Care Coordinator in the community (as defined in NC G.S. 122C). A qualified professional (QP) is equivalent to the federally defined qualified mental retardation professional.

Annual re-determination of LOC is performed by a QP as defined in NC General Statutes 122C-3:

“Qualified Professional means any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors.” As noted previously, NC Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, section 10A NCAC 27G.0103 18 (a)-(d) describe requirements for qualified professionals.

Qualified professionals providing the annual LOC reevaluation are care coordinators (case managers).

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

THE PIHP maintains a computerized tracking system of all level of care evaluations with their annual reevaluation due date. The data is reviewed monthly by THE PIHP. The care coordinator is notified if the evaluation is received outside the approved timeline.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are

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maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of each initial LOC evaluation must be maintained by the PIHP for a minimum period of five years.

Copies of the initial level of care determination are maintained in the participant's record by the PIHP care coordinator as well as in the PIHP administrative files.

The PIHP is responsible for maintaining records of reevaluations for a minimum of five years for those participants over the age of 18. For participants not over the age of 18, documents must be maintained until their 23rd birthday. The documents will be physically maintained at the respective PIHP and Care Coordinator office.

The annual re-evaluation document is maintained in written form by the Care coordinator and the administrative files of the PIHP.

Quality Management: Level of Care.

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

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	<i>Proportion of Level of Care evaluations completed within 30 days of identification of needed services.</i>		
Data Source:	Responsible party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling approach <i>(check each that applies):</i>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review

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	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis: (check each that applies):	Method of aggregation reporting: (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-Annually	

DELETED MEASURE REGARDING NUMBER OF LOC DECISIONS APPEALED AND OVERTURNED

a.i.b Sub-Assurance: The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	Proportion of LOC re-evaluations completed at least annually for enrolled participants by their birth month.		
Data Source Care coordinator CNR data or PIHP Care coordinator Unit file	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	

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	<i>Agency</i>		
	■ <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
	THE PIHP	■ <i>Other (Specify):</i>	
		Semi-Annually	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	■ <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other (Specify):</i>
	■ <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	
	THE PIHP	■ <i>Other (Specify):</i>	
		Semi Annually	

a.i.c Sub-assurance: The processes and instruments described in the approved waiver are applied to determine LOC.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	Proportion of LOC evaluations on <u>new</u> participants which are completed using approved processes and instrument.		
Data Source Care coordinator CNR data or THE PIHP Care Management unit	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	■ <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	
	■ <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified:</i>

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			<i>Describe Group</i>
	THE PIHP	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Semi-Annually	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other (Specify):</i>
	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	
	THE PIHP	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Semi Annually	

Performance Measure:	Proportion of LOC evaluations for <u>existing</u> participants completed using approved processes and instrument.		
Data Source Care coordinator CNR data or THE PIHP Care Management unit	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
	THE PIHP	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Semi-Annually	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other (Specify):</i>
	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	
	THE PIHP	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Semi Annually	

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DELETED MEASURE: *Proportion of LOC eligibility determination packets that were returned to the PIHP for incompleteness of documentation.*

DELETED MEASURE: *Proportion of applicants reviewed whose initial or subsequent LOC outcome was appropriately determined. N=Number of randomly selected waiver participants who do not have a diagnosis of mental retardation or and approved related condition.*

DELETED MEASURE: *Proportion of applicants, who receive a waiver slot and an approved LOC, who begin receiving services within 90 days after being prioritized for a slot.*

a.ii Remediation Data Aggregation

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

N/A

b. Methods for Remediation

b.i *Describe the States strategy for addressing individual problems as they are discovered.*

The PIHP will address and correct problems identified on a case-by-case basis and include the information in the report to DMA and the Intra-departmental Monitoring Team. DMA may require a corrective action plan(s) if problems are identified. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	The PIHP	<input type="checkbox"/> Other (Specify):	

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c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

Appendix B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. Procedures.** Specify the State’s procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When funding is available, prospective participants are informed of their feasible alternatives under the waiver and their option to choose waiver services as an alternative to institutional ICF-MR services by THE PIHP. This decision is documented on the ISP signature page. Annually, thereafter, the Freedom of Choice option is reviewed with the participant or the legally responsible person and the decision documented on the Individual Support Plan.

- b. Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice statement is maintained in written form as a component of the ISP and is found in the record of PBH care coordinator file and the administrative files of PBH.

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Appendix B-8: Access to Services by Limited English Proficient Persons

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

THE PIHP makes available, to participants with limited English proficiency and their legally responsible representatives, materials that are translated into the prevalent non-English languages of the state. PBH makes interpreter services available to individuals with limited English proficiency through a contract with a telephone language line and contracts with individual providers in the community for on-site interpretation. THE PIHP complies with the DHHS Title VI Language Access Policy.

The North Carolina DHHS has implemented a language access policy to ensure that individuals with limited English proficiency (LEP) have equal access to benefits and services for which they may qualify from entities receiving federal financial assistance. The policy applies to the North Carolina DHHS, all divisions/institutions within DHHS and all programs and services administered, established or funded by the Department, including subcontractors, vendors and sub-recipients.

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

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (<i>check each that applies</i>)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input checked="" type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input checked="" type="checkbox"/>	Residential Supports
Day Habilitation	<input checked="" type="checkbox"/>	Day Supports
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (<i>select one</i>)		
<input type="checkbox"/>	Not applicable	
<input checked="" type="checkbox"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Assistive Technology Equipment and Supplies	
b.	Community Guide Services	

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c.	Community Networking Services	
d.	Community Transition Services	
e.	Crisis Services	
f.	In-Home Skill Building	
g.	In-Home Intensive Supports	
h.	Home Modifications	
i.	Individual Goods and Services	
j.	Natural Supports Education	
k.	Specialized Consultation Services	
l.	Vehicle Modifications	
Extended State Plan Services (select one)		
<input checked="" type="checkbox"/>	Not applicable	
<input type="checkbox"/>	The following extended state plan services are provided (<i>list each extended State plan service by service title</i>):	
a.		
b.		
c.		
Supports for Participant Direction (check each that applies)		
<input checked="" type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes information and assistance in support of participant direction, financial management services or other supports for participant direction as waiver services.	
<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.	
<input type="checkbox"/>	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input checked="" type="checkbox"/>	Community Guide
Financial Management Services	<input checked="" type="checkbox"/>	Financial Supports Services

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Other Supports for Participant Direction (*list each support by service title*):

a.	
b.	
c.	

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a waiver service defined in Appendix C-3 (<i>do not complete C-1-c</i>)
<input type="checkbox"/>	As a Medicaid state plan service under §1915(i) of the Act (HCBS as a state plan option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input checked="" type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Under the 1915(b)/1915(c) concurrent waivers, THE PIHP conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c).

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Appendix C-2: General Service Specifications

- a. **Criminal History and/or Background Investigations.** Specify the State’s policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

<input checked="" type="checkbox"/>	<p>Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</p> <p>Criminal background checks must be conducted prior to hiring the employee in all situations described below.</p> <p>As provided by NC G.S. 122C-80, criminal background checks must be conducted on all prospective employees of licensed MH/DD/SAS provider agencies who may have direct access to individuals served. PIHP licensed contract agencies must comply with this law. This includes direct care positions, administrative positions and other support positions that have contact with individuals served. When prospective employees have lived in North Carolina for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.</p> <p>As required by Cardinal Innovations Service Provider Qualifications, unlicensed provider agencies who contract to provide NC Innovations services must also conduct criminal background checks on all prospective employees who may have direct access to individuals served. THE PIHP conducts criminal background checks on independent practitioners.</p> <p>When participants elect the Individual and Family Directed Services Option, criminal background checks must be obtained for any job applicant under serious consideration. Criminal background checks are provided without charge as a component part of Financial Supports Services in the employer of record Model. In the Agency with Choice Model, the agency obtains a criminal background check prior to hiring any employee referred for hire by a Managing Employer.</p> <p>THE PIHP reviews the provider agency (including agencies offering self-direction under Agencies with Choice options) criminal record check policy at the time of initial credentialing of the agency and re-verifies agency credentials, including a sample of criminal background checks, at a frequency determined by THE PIHP, no less than every three years. Annually, THE PIHP reviews employer of record personnel practices to ensure that there is documentation of the criminal background check for each employee hired.</p>
<input type="checkbox"/>	<p>No. Criminal history and/or background investigations are not required.</p>

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

<input checked="" type="checkbox"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p> <p>Abuse registry screenings must be conducted prior to hiring the employee in all situations discussed below.</p> <p>As provided by NC G.S. 131E and NC G.S. 122C, the DHHS, Division of Health Service Regulation, maintains the Abuse Registry.</p> <p>Licensed agencies who contract with THE PIHP must conduct abuse registry screenings of prospective employees for positions who have direct access to individuals receiving services. Information from both the Nurse Aide Registry and the Health Care Personnel Registry is available to the general public and all health care providers via the Internet through a 24-hour telephone voice response system.</p> <p>As required by NC Innovations Service Provider Qualifications, unlicensed agencies that contract with THE PIHP to provide NC Innovations services are also required to conduct Abuse Registry screenings of prospective employees who provide waiver services to participants.</p> <p>When participants elect the Individual and Family Directed Services Option, Abuse Registry screenings must be conducted for any job applicant under serious consideration. Abuse Registry screenings are provided without charge as a component part of Financial Supports Services in the employer of record Model. In the Agency with Choice Model, the Agency obtains an Abuse Registry Screening prior to hiring any employee referred for hire by a managing employer.</p> <p>THE PIHP reviews the provider agency (including Agencies with Choice) abuse registry screening policy at the time of initial credentialing and re-verifies agency credentials, including a sample of Abuse Registry screenings, at a frequency determined by THE PIHP, no less than every three years. THE PIHP reviews employer of record personnel practices annually to ensure that necessary screenings have been performed prior to employment.</p>
<input type="checkbox"/>	<p>No. The State does not conduct abuse registry screening.</p>

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

<input type="checkbox"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input checked="" type="checkbox"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i></p>

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i. **Types of Facilities Subject to §1616(e).** Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
<p>Supervised Living facilities, type B serving minors with a primary diagnosis of a developmental disability and type C serving adults with a primary diagnosis of developmental disability.</p>	<p>Residential Supports</p>	<p>Per State licensure rule, types B and C supervised living facilities cannot exceed 6 beds except that any facility licensed on June 15, 2001, for more than six clients 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; in addition, any facility with greater than 6 beds will have no new admissions of waiver recipients; newly developed facilities may participate in the waiver only if they are licensed for 3 beds or less.</p>

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<p>Supervised living facilities type F serve either minors or adults with a developmental disability</p> <p>Family care homes</p>		<p>Type F supervised living facilities cannot exceed 3 beds per State licensure rules; to participate in the waiver, the facilities must meet waiver home and community characteristics.</p> <p>Family care homes cannot exceed 6 beds per state licensure rules; family care homes must meet waiver home and community characteristics to participate in the waiver. Newly developed facilities may participate in the waiver only if they are licensed for 3 beds or less.</p>
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- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings:

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 an individual'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
 - Operation 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 circumstance 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

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- 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 that the individual has an active role in directing the process
- Person centered planning process must be at convenient locations and times for the 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 facility's recreational activities
 - Residents must be allowed to chose 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:

The State will require the managed care entities to conduct a review of each facility with four or more beds (# of beds specified in the 1915(c) Technical Review 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 participation in the Innovations program. 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 managed care entity and if the facility is fully compliant, the suspension will be lifted. If not, the facility will be terminated from the Innovations program and waiver participants residing in the facility will be required to move in order to continue participating in the waiver.

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iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type
	Facilities for the Mentally Ill, Developmentally Disabled and Substance Abusers		
Admission policies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform, or be responsible to perform, on behalf of a waiver participant. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
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<input type="checkbox"/>	<p>Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.</i></p>
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e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

<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>

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The following relatives may provide services: 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 skill building, in-home intensive supports, 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 ISP.
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.
12. The use of a neutral advocate will be 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.

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<input type="checkbox"/>	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. 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>
<input type="checkbox"/>	Other policy. <i>Specify:</i>

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Under its risk contract with DMA, THE PIHP must establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of individuals served through the concurrent §1915(b)/ §1915(c) waivers. THE PIHP must analyze its provider network and demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access by beneficiaries to practitioners and facilities. The analysis is reviewed by DMA at the beginning of each contract period; at any time there has been a significant change in PIHP operations that may affect the adequacy of capacity and services, including changes in services, benefits, geographic service areas or payments or enrollment of a new population in the concurrent waivers; and annually thereafter during the annual site visits by the Intradepartmental Monitoring Team (IMT). Whenever network gaps are noted, THE PIHP submits to DMA a network development strategy or plan to fill the gaps, as well as periodically reports to DMA on the implementation plan or strategy.

Quality Management: Qualified Providers

As a distinct component of the State’s quality management strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery:

a.i.a Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

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Performance Measure:	<i>Proportion of new providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services. N: Number of new C waiver providers reviewed who meet the requirements to furnish C waiver services D: Number of new C waiver providers who were reviewed</i>		
Data Source Provider performance monitoring	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Proportion of existing providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services. N: Number of existing C waiver providers reviewed who meet the requirements to furnish C waiver services D: Number of existing C waiver providers who were reviewed</i>		
Data Source Provider performance monitoring	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	

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	<input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
		<input checked="" type="checkbox"/> <i>Other (Specify):</i> Semi-Annually	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies): <input type="checkbox"/> <i>State Medicaid Agency</i> <input type="checkbox"/> <i>Operating Agency</i> <input type="checkbox"/> <i>Case Management Agency</i> <input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	Frequency of data aggregation and analysis (check each that applies): <input type="checkbox"/> <i>Weekly</i> <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Quarterly</i> <input checked="" type="checkbox"/> <i>Annually</i> <input type="checkbox"/> <i>Other (Specify):</i>	Method of aggregation reporting (check each that applies): <input checked="" type="checkbox"/> <i>Narrative Report</i> <input checked="" type="checkbox"/> <i>Data Compilation</i> <input type="checkbox"/> <i>Other: Specify</i>
Performance Measure:	<i>Proportion of providers reviewed, according to THE PIHP monitoring schedule, to determine continuing compliance with licensing, certification, contract and waiver standards.</i>		
Data Source Provider performance monitoring	Responsible party for data collection/generation (check each that applies): <input type="checkbox"/> <i>State Medicaid Agency</i> <input type="checkbox"/> <i>Operating Agency</i> <input type="checkbox"/> <i>Case Management Agency</i> <input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	Frequency of data collection/generation (check each that applies): <input type="checkbox"/> <i>Weekly</i> <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Quarterly</i> <input type="checkbox"/> <i>Annually</i> <input checked="" type="checkbox"/> <i>Other (Specify):</i> Semi-Annually	Sampling approach (check each that applies): <input type="checkbox"/> <i>Representative Sample</i> <input checked="" type="checkbox"/> <i>100% Review</i> <input type="checkbox"/> <i>Stratified: Describe Group</i> <input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies): <input type="checkbox"/> <i>State Medicaid Agency</i> <input type="checkbox"/> <i>Operating Agency</i> <input type="checkbox"/> <i>Case Management Agency</i> <input checked="" type="checkbox"/> <i>Other (Specify):</i> PIHP	Frequency of data aggregation and analysis (check each that applies): <input type="checkbox"/> <i>Weekly</i> <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Quarterly</i> <input checked="" type="checkbox"/> <i>Annually</i> <input type="checkbox"/> <i>Other (Specify):</i>	Method of Aggregation Reporting (check each that applies): <input checked="" type="checkbox"/> <i>Narrative Report</i> <input checked="" type="checkbox"/> <i>Data Compilation</i> <input type="checkbox"/> <i>Other (Specify):</i>

Performance	<i>Proportion of providers for whom problems have been discovered and</i>
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Measure:	appropriate remediation has taken place.		
Data Source Provider performance monitoring to include plans of correction	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of Aggregation Reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other (Specify):	

a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	Proportion of non-licensed/non-certified providers that are found to be fully in compliance with the waiver requirements when reviewed according to THE PIHP's State-approved monitoring schedule.
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Data Source Provider performance monitoring	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with 95% confidence interval
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of Aggregation Reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

a.i.c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	Proportion of network providers that have received provider training in accordance with state requirements and the approved waiver.		
Data Source Provider Training Records	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):

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	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with 95% confidence interval
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of Aggregation Reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other (Specify):	

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

N/A

b. Methods for Remediation

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

THE PIHP will address and correct problems identified on a case by case basis and include the information in the report to DMA and the IMT. DMA may require a corrective action plan if the problems identified appear to require a change in THE PIHP's processes for making accurate and timely decisions regarding level of care. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

Any provider issues that affect the health and safety of waiver participants are reported to DMA immediately.

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b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of Aggregation Reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other (Specify):
	<input type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other (Specify):	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

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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	
Service Title:	Personal Care
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" 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 type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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.</p> <p>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 participants' family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation and use of special mobility devices.</p> <p>Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the supports described in the ISP. Services may be allowed in the private home of the provider or staff of an employer of record 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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>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.</p> <p>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.</p> <p>This service may not be provided at the same time of day that a participant receives: Day supports, in-home skill building, community networking, respite care, supported employment, or in-home intensive supports.</p>	

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Personal Care cannot be provided in a licensed program.

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

For participants who are eligible for educational services under the Individuals with Disabilities Education 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 Support Need Matrix Category budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix.

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 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)			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: <ul style="list-style-type: none"> Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health nor safety risk to participant Not listed in the North Carolina Health Care Abuse Registry

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			<ul style="list-style-type: none"> • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) 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 • State Nursing Board regulations must be followed for tasks that present health and safety risks to the participant as directed by THE PIHP Medical Director or Assistant Medical Director • Agencies with Choice follow the NC State Nursing Board regulations • Has an arrangement with an enrolled Crisis Services provider to respond to participant crisis situations • Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of
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			<p>THE PIHP. 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.</p>
<p>Home Health Agency</p>	<p>Licensed by the Division of Health Service Regulation as a Home Care Agency</p>		<p>Approved as a provider in THE PIHP provider network</p> <p>Agency staff that work with participants:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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

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			<p>crisis services provider to respond to participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however.</p> <ul style="list-style-type: none"> • 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 PIHPPIHP. Services provided in private home of the direct service employee are subject to the checklist and monthly monitoring by the provider agency qualified professional.
<p>Personal Care Service Provider</p>			<p>Approved as a provider in THE PIHP provider network.</p> <p>Staff Qualifications:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this service must be supervised by a

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			<p>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.</p> <ul style="list-style-type: none"> • Enrolled to provide crisis services or has an arrangement with an enrolled crisis services provider to respond to participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however. • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of PIHP. • Services provided in private home of the direct service employee are subject to the checklist and monthly monitoring by the provider agency qualified professional.
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Care Self-Employed Individual (Self-Direction Only)	PIHP	Prior to hiring and annually thereafter
Home Health Agency	PIHP	Prior to initial enrollment and at least every three years thereafter
Personal Care Service Provider	PIHP	Prior to initial enrollment and at least every three years thereafter

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Service Specification

Service Title: **Residential Supports**

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

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

Service Definition (Scope):

Residential Supports consists 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 individual 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.**

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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 meets 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 a THE PIHP AFL checklist for health and safety related issues.

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 Plan Transportation rather than Residential Supports.

Participants who receive Residential Supports may not receive In-Home Skill Building, In-home Intensive Treatment, Vehicle Modifications, Respite, Home Modifications, Personal Care or State Plan Personal

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

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.

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

The amount of Residential Supports is subject to the “Limits on sets of services” as well as the Support Needs Matrix category budget if currently phased into the Support Needs Matrix as specified in Appendix C-4.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
			Provider Agencies	

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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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>
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: B		Approved as a provider in THE PIHP provider network: <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this
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	10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147 Type: C		

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<p>15, 2001 for more than six clients at that time may be grandfathered at no more than the facility's licensed capacity.</p>			<p>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.</p> <ul style="list-style-type: none"> • Enrolled to provide crisis services or has an arrangement with an enrolled crisis services provider to respond to participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however. • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
<p>Supervised living facilities type F serve no more than 3 minors or 3 adults with a developmental disability</p>	<p>10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147</p>		<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe

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<p>Unlicensed supervised living homes may only serve one adult based on 10A NCAC 27 G.5601 (b) (1) (2)</p>	<p>Type: F</p> <p>NA</p>		<p>driving record and an acceptable level of automobile liability insurance</p> <ul style="list-style-type: none"> • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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 participant may select any enrolled crisis services provider in lieu of this provider however. • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. • The organization must be established as a legally constituted
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			<p>entity capable of meeting all of the requirements of THE PIHP. Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care.</p> <ul style="list-style-type: none"> • Back up staff must be employees of the agency.
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
<p>Supervised Living facilities Types B and C 3 beds or less for newly developed facilities; 6 beds or less for existing facilities.</p>	<p>The North Carolina Department of Health and Human Services, Division of Health Services Regulation (DHSR) inspects and licenses supervised living homes. The facility verifies employee qualifications The PIHP re-verifies agency credentials, including a sample of employee qualifications upon initial review and no less than every three years.</p>	<p>DHSR-Facility is relicensed annually Facility employee verification of employee qualifications –upon hiring PIHP credentialing- no less than every 3 years</p>
<p>Supervised living facilities type F serve no more than 3 minors or 3 adults with a developmental disability</p>	<p>DHSR-Facility is relicensed annually Facility employee verification of employee qualifications –upon hiring PIHP credentialing- no less than every 3 years</p>	<p>DHSR-Facility is relicensed annually Facility employee verification of employee qualifications –upon hiring PIHP credentialing- no less than every 3 years</p>
<p>Unlicensed supervised living homes may only</p>	<p>Local Management entity (LME)/PIHP</p>	<p>The facility is monitored according to the requirements</p>

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serve one adult based on 10A NCAC 27 G.5601 (b) (1) (2)		of the Frequency and Extent Monitoring (FEM) tool by the PIHP. The PIHP credentials the facility initially and at least every 3 years.		
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Service Specification	
Service Title:	Day Supports
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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 individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational or speech therapies listed in the ISP. 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.</p> <p>This service shall not be furnished/billed at the same time of day as community networking, in-home skill building, in-home intensive supports, personal care, residential supports and/or supported employment or one of the State Plan Medicaid services that works directly with the person.</p> <p>Day Supports may include prevocational activities. The following criteria differentiate between prevocational and vocational services.</p> <ul style="list-style-type: none"> • 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. • If compensated, the participant may, on average, receive less than 50 percent of minimum wage. • Services include activities that are not directed at teaching job-specific skills but at underlying rehabilitative goals (e.g., attention span, motor skills, attendance, task completion). <p>Day Supports may not be used for the provision of vocational services (e.g., sheltered work performed 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 rehabilitative skills required for obtaining a job may be provided in the licensed day support setting.</p> <p>Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the ISP 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. This service may not duplicate services provided under community networking, in-home skill building, in-home intensive supports, personal care, residential supports and/or supported employment.</p> <p>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, provider home where the participant is receiving services before/after school or any community location where the participant may be receiving services before or</p>	

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after school.

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

The amount of Day Supports is subject to the “Limit on Sets of Services” specified in appendix C-4. The amount of Day Supports also is subject to the amount of the participant’s Support Need Matrix Category Budget if currently phased into the Support Needs Matrix as specified in Appendix C-4.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
			Provider Agencies	
			Adult Day Health and Adult Day Care Programs	
			Licensed Developmental Day Care Programs	
		Before and After School Day Care Programs operated by NC Public School System		

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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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>
Provider Agencies	NC G.S. 122 C	NC G.S. 122 C	Approved as a provider in THE PIHP provider network: <ul style="list-style-type: none"> Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health nor safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Staff that work with participants must be qualified in CPR and First Aid Staff that work with participants must have a high school diploma or high school equivalency (GED) Staff that work with participants must be qualified in the customized needs of the participant as described in the

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			<p>ISP.</p> <ul style="list-style-type: none"> 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 Adult Day Care Programs		Certified by NC Division of Aging	<p>Approved as a provider in THE PIHP provider network</p> <p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health nor safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Staff that work with participants must be qualified in CPR and First Aid Staff that work with participants

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			<p>must have a high school diploma or high school equivalency (GED)</p> <ul style="list-style-type: none"> • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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.122C	<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the

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			<p>ISP.</p> <ul style="list-style-type: none"> • 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.
<p>Before and After School Day Care Programs Operated by NC Public School System</p>			<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the

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			<p>participant as described in the ISP.</p> <ul style="list-style-type: none"> • 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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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Provider Agencies	<p>Provider Agencies</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years</p>
Adult Day Health and Adult Day Care Programs	<p>Adult Day Health and Adult Day Care Programs</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years</p>
Developmental Day	Developmental Day Care Programs	Verifies employee qualifications

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Care Programs	PIHP	at the time employee is hired Upon initial review, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Before and After School Day Care Programs Operated by the NC Public School Programs	Before and After Day Care School Programs PIHP	Verifies employee qualifications at the time employee is hired Upon initial review, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Supported Employment
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
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:	
<ol style="list-style-type: none"> 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 	

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a business plan, including potential sources of business financing and other assistance, ; and (c) identification of the supports that are necessary in order for the 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 a 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

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Documentation will be maintained in the file of each provider agency or employer of record 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.

Exclusions

FFP is not 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
- 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 Individual’s With Disability Educational Act Supported Employment 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.

This service is not available at the same time of day as community networking, day supports, in-home skill building, in-home intensive services, residential supports, respite, personal care or one of the State Plan Medicaid services that works directly with the person.

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

The amount of Supported Employment Services is subject to the “Limit on Sets of Services” specified in Appendix C-4. The amount of Supported Employment Services also is subject to the amount of participant’s Support Need Matrix Category Budget if currently phased into the Support Needs Matrix as specified in Appendix C-4.

Provider Specifications

Provider	■	Participant. List types:	■	Agency. List the types of agencies:
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Category(s) <i>(check one or both):</i>		Employee in a self-directed arrangement	Provider Agencies
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 <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Employee in a self-directed arrangement		NC G.S.122C, as applicable	<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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED), 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) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified

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			<p>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</p> <ul style="list-style-type: none"> • 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 <p>Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. Competencies as specified by THE PIHP.</p>
<p>Provider Agencies</p>		<p>NC G.S.122C</p>	<p>Approved as a vendor in THE PIHP provider network</p> <p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants

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			<p>must be qualified in CPR and First Aid</p> <ul style="list-style-type: none"> • 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) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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, enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. • Competencies as specified by THE PIHP.
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employee in a self-directed arrangement	Employer of Record or Agency with Choice	Prior to hire Employer of Record annually

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Appendix C: Participant Services
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	PIHP	Agency with Choice as specified for provider agencies
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial reviews, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Respite
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. 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 (10) consecutive days. The primary caregiver is the person principally responsible for the care and supervision of the individual and must maintain his/her primary residence at the same address as the individual.</p> <p><u>Exclusions</u> This service may not be used as a daily service in individual support. This service is <u>not</u> available to individuals who receive residential supports and/or those who live in licensed residential settings or AFL homes. Staff sleep time is not reimbursable. Respite services are only provided for the individual; other family members, such as siblings of the individual, may not receive care from the provider while respite care is being provided/billed for the individual. Respite care is not provided by any individual who resides in the individual'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.</p>	

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For participants who are eligible for educational services under the Individual's With Disability Educational Act, Respite 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.

This service is not available at the same time of day as in-home skill building, in-home intensive services, community networking, day supports, supported employment, residential supports, personal care, specialized consultation services, or one of the regular Medicaid services that works directly with the participant

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

The cost for 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 participant's Support Needs Matrix Category budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix . Respite may not be used for participants who are living alone or with a roommate; staff sleep time is not reimbursable.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
		Individual Selected by the Participant		Provider Agencies
				Provider Agencies who operate private respite homes
				Nursing Respite, Provider Agencies
				Nursing Respite, Home Care Agencies
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input 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>
Employee in a self-directed arrangement		NC G.S.122C , as applicable	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: <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk

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			<p>to participant</p> <ul style="list-style-type: none"> • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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. • Upon enrollment with THE PIHP, enrollment as a provider, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting
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			<p>agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.</p>
<p>Provider Agencies, facility based and in-home services</p>	<p>NC G.S.122C</p>	<p>NC G.S. 122-C</p>	<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. Associate professionals providing supervision to paraprofessionals

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			<p>on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012</p> <ul style="list-style-type: none"> • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. • Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the provider agency qualified professional.
<p>Provider Agencies who operate private respite homes</p>	<p>Private home respite services serving individuals outside their private home are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently or either one or two children, two adults, or any combination thereof, are served for a cumulative period of time exceeding 240 hours per calendar month.</p>	<p>NC G.S. 122-C</p>	<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided

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			<p>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</p> <ul style="list-style-type: none"> • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. • Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.
Nursing Respite, Provider Agencies		NC G.S. 122-C	<p>Approved as a provider in THE PIHP provider network</p> <p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • 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 nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants

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			<p>must be qualified in CPR and First Aid</p> <ul style="list-style-type: none"> • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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 Agency with Choice qualified professional or the Employer of Record.
Home Care Agencies	Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6, Part C		<p>NC G.S. 122C, as applicable Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • Provided by an RN or LPN licensed in the State of North Carolina

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			<ul style="list-style-type: none"> • If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health nor safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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. <p>Services provided in the private home of the direct service employee are subject to</p>
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			the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:	
Employee in a self-directed arrangement	Employer of Record or Agency with Choice PIHP	Prior to hire Employer of Record Annually Agency with Choice as specified for provider agencies	
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years	
Provider Agencies who operate private respite homes	Provider Agencies, Private Respite Homes PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years	
Nursing Respite, Provider Agencies	Nursing Respite Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years	
Home Care Agencies	Home Care Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency	

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		credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Assistive Technology Equipment and Supplies
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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 ISP 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.</p> <p>Assistive Technology: Equipment and Supplies covers the following:</p> <p><u>I. Aids For Daily Living</u></p> <p>(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)</p> <p>(2) Adaptive hygiene and dressing aids</p> <p>(3) Adaptive switches and attachments</p> <p>(4) Adaptive toileting and bath chairs</p> <p>(5) Adaptive toothbrushes</p> <p>(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 tele-touch systems)</p>	

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- (7) Food/fluid thickeners for dysphasia treatment
- (8) Positioning chairs
- (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 covered by Medicaid State plan as a Home Infusion Therapy benefit
- (12) Special clothing to meet the unique needs of the participant
- (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 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 diversional activities or to be used by any other person other than the participant.

IV. Positioning Systems

- (1) Standers with trays and attachments (for adults only – children receive under the State Plan)
- (2) Prone boards with attachments (for adults only – children receive under the State Plan)
- (3) Positioning chairs and sitters for participants that 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 required 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 and 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

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visual loss.

- (3) Telephone line restoration systems when a 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 ISP 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 ISP 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.

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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.

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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.

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

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.

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:
		Specialized Vendor Suppliers		Alert Response Centers
				Durable Medical Equipment Providers
				Home Care Agencies
				Commercial/Retail Businesses

Specify whether the service may be Legally Responsible Relative/Legal Guardian

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provided by (check each that applies):	<input type="checkbox"/>	Person	<input type="checkbox"/>	
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor 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 vendor 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 vendor 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	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:		
Specialized Vendors	PIHP	Prior to first use		
Alert Response Centers	PIHP	Prior to first use		
Durable Medical Equipment Providers	PIHP	Prior to first use		
Home Care Agencies	PIHP	Prior to first use		
Commercial/Retail Businesses	PIHP	Prior to first use		
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

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Service Specification	
Service Title:	Community Guide
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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.</p> <p>These services also support participants, representatives, employers 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; however, a formal fading plan is not required. 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.</p> <p>Specific functions are:</p> <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) goals; 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) Provide training on the Individual and Family Directed Supports Option, if the participant is considering directing services and supports (Agency with Choice and Employer of 	

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Record)

- (8) Guidance with management of the participant directed budget (Agency with Choice and Employer of Record)
- (9) Coordinating services with the FSS provider, if the participant is self-directing services under the Employer of Record Model, including guidance on use of the individual and family directed budget (self-directed budget) (Employer of Record)
- (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)
- (11) Assisting with the development of schedules and outlining staff duties, if the participant is self-directing services (Agency with Choice and Employer of Record)
- (12) Assisting with understanding staff financial forms, qualifications and record keeping requirements, if the participant is self-directing services (Agency with Choice and Employer of Record)
- (13) Providing on-going information to assure that participants and their families/representatives understand the responsibilities involved with self-direction, including reporting on expenditures and other relevant information and training (Agency with Choice and Employer of Record)
- (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

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).

Exclusions

- The provider of Community Guide Services that does not provide Agency With Choice Services may only additionally provide Community Transition, Financial Support Services, and Individual Goods and Services to the same participant.
- 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.

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

The amount of community guide 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 .

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="radio"/>	Individual. List types:	<input type="radio"/>	Agency. List the types of agencies:
		Employee in a self-directed arrangement		Provider Agencies

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Appendix C: Participant Services
 HCBS Waiver Application Version 3.5

Specify whether the service may be provided by (<i>check each that applies</i>):		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative and Legal Guardian
Provider Qualifications (<i>provide the following information for each type of provider</i>):			
Provider Type:	License (<i>specify</i>):	Certificate (<i>specify</i>):	Other Standard (<i>specify</i>):
Employee in a self-directed arrangement			<ul style="list-style-type: none"> • NC G.S. 122C as applicable • Approved by employer of record or recommended by managing employer and approved by Agency with Choice At least 18 years old • Able to effectively read, write and communicate verbally in English, understand instructions and perform record keeping • If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background checks present no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Qualified in CPR and First Aid and the customized needs of the participant as described in the ISP • High school diploma or equivalency and supervised by the employer of record or managing employer • Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities employed by Agency with Choice, if electing Agency with Choice model • Meets community guide competencies as specified by THE PIHP
Provider agencies		NC G.S. 122C, as applicable	Approved as a provider in THE PIHP provider network: <ul style="list-style-type: none"> • Are at least 18 years old

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			<ul style="list-style-type: none"> • If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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 specified by THE PIHP
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Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification:
Employee in a self-directed arrangement	Employer of Record or Agency with Choice PIHP		Prior to hiring Employer of Record annually Agency with Choice, as specified for provider agencies
Provider Agencies	Provider Agency PIHP		Verifies employee qualifications at the time employee is hired Upon initial review, PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Community Networking
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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.</p> <p><u>Community networking services consist of:</u></p> <p>(1) Participation in adult education</p>	

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- (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
- (9) For children, this service includes staffing supports to assist children to participate in day care/after school summer programs that typically serve 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 to an integrated community setting or a self advocacy activity.

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 for overnight programs of any kind. 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, home supports, residential supports and/or supported employment services.

This service may not be furnished/claimed at the same time of day as day supports, home supports, 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 Individual’s With Disability Educational Act, Community networking 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.

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.

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

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

Provider Specifications

Provider	■	Individual. List types:	■	Agency. List the types of agencies:
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Category(s) <i>(check one or both):</i>		Employee in a self-directed arrangement	Provider Agency
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 and Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify):</i>	Certificate <i>(specify):</i>	Other Standard <i>(specify):</i>
Employee in a self-directed arrangement			<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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the

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			<p>appropriate discipline. Associate professional providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012</p> <ul style="list-style-type: none"> • State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by THE PIHP Medical Director or Assistant Medical Director • Agencies with Choice follow the NC State Nursing Board regulations • Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
Provider Agencies			<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the

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			<p>participant as described in the ISP</p> <ul style="list-style-type: none"> • 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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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Employee in a self-directed arrangement	Employer of Record or Agency with Choice PIHP	Prior to hiring Employer of Record annually Agency with Choice as specified for provider agencies
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
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Service Specification					
Service Title:	Community Transition				
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.				
<input type="checkbox"/>	Service is not included in the approved waiver.				
Service Definition (Scope):					
<p>Community transition is a one-time, set-up expense 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 non-provider owned, private 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.</p> <p><u>Covered transition services are:</u></p> <ol style="list-style-type: none"> (1) Security deposits that are required to obtain a lease on an apartment or home (2) Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens (3) Moving expenses required to occupy and use a community domicile (4) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water and/or (5) Service necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy <p>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 wavier 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.</p> <p><u>Exclusions</u></p> <p>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.</p>					
Specify applicable (if any) limits on the amount, frequency or duration of this service:					
The cost of community transition is a lifetime limit of \$5,000.00 per participant.					
Provider Specifications					
Provider Category(s) <i>(check one or both):</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"><input checked="" type="checkbox"/> Individual. List types:</td> <td style="width: 50%; text-align: center; padding: 5px;"><input checked="" type="checkbox"/> Agency. List the types of agencies:</td> </tr> <tr> <td style="text-align: center; padding: 5px;">Specialized Vendor Suppliers</td> <td style="text-align: center; padding: 5px;">Agencies that provide Community Guide and Financial Support Services</td> </tr> </table>	<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	Specialized Vendor Suppliers	Agencies that provide Community Guide and Financial Support Services
<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:				
Specialized Vendor Suppliers	Agencies that provide Community Guide and Financial Support Services				

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Commercial/Retail Businesses			
Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (<i>provide the following information for each type of provider</i>):			
Provider Type:	License (<i>specify</i>):	Certificate (<i>specify</i>):	Other Standard (<i>specify</i>):
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
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification:
Specialized Vendor Suppliers	PIHP		At the time of first use
Agencies that provide Community Guide Services	PIHP		Upon initial credentialing PIHP re-verifies agency credentials at a frequency determined by THE PIHP, no less than every three years
Commercial/Retail Businesses	PIHP		At the time of first use
Service Delivery Method			
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
			Provider managed

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Service Specification	
Service Title:	Crisis Services
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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 ISP to meet the needs of the participant. Following service authorization, any needed modifications to the ISP and individual budget will occur within five (5) working days of the date of verbal service authorization.</p> <p><u>Primary Crisis Response</u></p> <p>Trained staff are available to provide “first response” crisis services to waiver participants they support, in the event of a crisis. These activities include:</p> <ol style="list-style-type: none"> (1) 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 (2) Determine and contact agencies needed to secure higher level intervention or out-of-home services (3) 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 (4) Contact the care coordinator following the intervention to arrange crisis behavioral consultation for the participant and/or (5) 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) <p><u>Crisis Behavioral Consultation</u></p> <p>Crisis behavioral consultation is available to participants that have significant, intensive, challenging behaviors that have resulted in a crisis situation requiring the development of a crisis support plan. These activities include:</p> <ol style="list-style-type: none"> (1) Development or refinement of interventions to address behaviors or issues that precipitated the 	

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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

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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/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 up to 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 under specialized consultation services.

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

Crisis services may be authorized for periods of up to 14 calendar day increments per event.

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			Provider Agencies	
		Provider Agencies who operate licensed facilities or private respite homes		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian

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

Provider Type:	License (specify):	Certificate (specify):	Other Standard (specify):
Provider Agencies Primary Crisis Response			Approved as a provider in THE PIHP provider network: <ul style="list-style-type: none"> • Are at least 18 years old • Provided by a qualified professional in the field of developmental disabilities, who meets competencies established by THE PIHP • If providing transportation, have

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			<p>a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <ul style="list-style-type: none"> • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR, First Aid and NCI • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. This includes national accreditation within the prescribed timeframe
<p>Independent Practitioners or Provider Agencies (Crisis Behavioral Consultation)</p>	<p>Licensure specific to discipline, if applicable</p>		<p>Approved by THE PIHP as an Independent Practitioner or as a provider in THE PIHP provider network</p> <p>Staff that work with individuals:</p> <p>Are at least 18 years old</p> <p>Criminal background check presents no health and safety risk to individual</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p>

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			<p>Staff holds NC license for psychologist or psychological associate</p> <p>Meets Crisis Services Competencies specified THE PIHP. See Appendix R.</p> <p>Qualified in customized needs of the individual as described in the ISP</p> <p>Within one year of January 1, 2011 or enrollment as a provider agency, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>The organization must be established as a legally constituted entity, capable of meeting all the requirements of THE PIHP.</p>
<p>Provider Agencies who operate licensed facilities</p>	<p>NC G.S, 122C</p> <p>10 NCAC 27G.5100 or waiver of licensure granted by licensing agency</p>		<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED)

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			<ul style="list-style-type: none"> • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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, 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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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Provider Agencies who operate licensed facilities	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample

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		of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E
	<input checked="" type="checkbox"/>	Provider managed

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Service Specification	
Service Title:	Home Modifications
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" 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 type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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.</p> <p>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.</p> <p><u>Covered Modifications are:</u></p> <p>(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</p>	

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- 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**

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).

Exclusions

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.

Modifications listed are exhaustive.

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.

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

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

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:
		Specialized Vendor Suppliers		Commercial/Retail Businesses
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input 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>
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.

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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.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:	
Specialized Vendors	PIHP	Prior to first use	
Commercial/Retail Businesses	PIHP	Prior to first use	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	In-Home Intensive Support
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Intensive support is available to support participants in their private home, when the participant needs extensive supervision and support. 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 night support needed by the participant.</p> <p>Authorization Process:</p> <ul style="list-style-type: none"> • In-home intensive supports may only be provided to participants who have exceptional medical or behavioral support needs on the Supports Intensity Scale assessment. • In-home intensive support requires prior authorization by THE PIHP. • In-home intensive support requires approval by THE PIHP at a minimum of every 90 days. <p>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.</p> <p>These services are provided in the participant’s private home, not in the home of the direct service employee. Participants 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.</p> <p><u>Exclusions</u></p> <p>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, residential supports, respite, supported employment, or personal care, or one of the State Plan Medicaid services that works directly with the person.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>The amount of in-home intensive support is subject to the “Limits on Sets of Services” specified in Appendix C-4. The amount of home supports also is subject to the amount of the Support Needs Matrix Category Budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix .</p>	
Provider Specifications	

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Appendix C: Participant Services
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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:
	Employee in a self-directed arrangement		Provider agencies	
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 <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify):</i>	Certificate <i>(specify):</i>	Other Standard <i>(specify):</i>	
Employee in a self-directed arrangement			<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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this 	

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			<p>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</p> <ul style="list-style-type: none"> • State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by THE PIHP Medical Director or Assistant Medical Director • Agencies with Choice follow the NC State Nursing Board regulations • Has an arrangement with an enrolled crisis services provider to respond to participant crisis situations. • 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.
<p>Provider Agencies</p>			<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • 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

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			<p>Health Care Abuse Registry</p> <ul style="list-style-type: none"> • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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 participant may select any enrolled crisis services provider in lieu of this provider however • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employee in a self-directed	Employer of Record Agency with Choice	Prior to hiring

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arrangement	PIHP	Employer of Record annually Agency with Choice as specified for provider agencies
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	In-Home Skill Building
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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 consist of an array of services that are required to maintain and assist the participant to live in community settings.</p> <p>In-home skill building consist of:</p> <ul style="list-style-type: none"> (1) Training in interpersonal skills and the 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 <p>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, 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</p>	

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caregiver or the provider/ employer of record. It is anticipated that the presence of in-home skill building will result in a gradual reduction in hours as the individual is trained to take on additional tasks and masters skills (fading plan). 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.

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 individual 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, respite, supported employment, personal care, in-home intensive support 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 skill building does not include transportation to/from school settings. This includes transportation to/from the participant’s home, provider’s 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.

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

The amount of in-home skill building is subject to the “Limits on Sets of Services” specified in Appendix C-4. The amount of in-home skill building also is subject to the amount of participant’s Support Needs Matrix Category Budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix .

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
		Employee in a self-directed arrangement		Provider agencies
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input 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>
Employee in a			Staff that work with participants are

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<p>self-directed arrangement</p>			<p>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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. 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
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			<p>present health and safety risks to the participant as directed by THE PIHP Medical Director or Assistant Medical Director</p> <ul style="list-style-type: none"> • Agencies with Choice follow the NC State Nursing Board regulations • Has an arrangement with an enrolled crisis services provider to respond to participant crisis situations • Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
Provider Agencies			<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals providing this

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			<p>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</p> <ul style="list-style-type: none"> • Enrolled to provide crisis services or has an arrangement with an enrolled crisis services provider to respond to participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however • Upon enrollment with THE PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Employee in a self-directed arrangement	<p>Employer of Record Agency with Choice</p> <p>PIHP</p>	<p>Prior to hiring</p> <p>employer of record annually Agency with Choice as specified for provider agencies</p>
Provider Agencies	<p>Provider Agencies</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE</p>

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		PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Individual Goods and Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" 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 type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Individual goods and services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the ISP (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements:</p> <p>(1) The item or service would decrease the need for other Medicaid services AND/OR</p> <p>(2) Promote inclusion in the community AND/OR</p> <p>(3) Increase the person's safety in the home environment AND</p> <p>(4) The individual does not have the funds to purchase the item or service</p> <p><u>Exclusions</u></p> <p>Individual goods and services do not include experimental goods and services inclusive of items, which may be defined as restrictive under NC G.S. 122C-60. This service is available only to individuals who self direct at least one of their services.</p>	

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

The cost of individual directed goods and services for each individual cannot exceed \$2,000.00 per participant plan year annually. The amount of individual goods and services 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:
		Employee in a self-directed arrangement	Commercial/Retail Businesses
			Financial Support Services Agency
			Agency with Choice

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			Community Guide
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 only in self-directed option and if the relative does not reside in the participant's home
Provider Qualifications (<i>provide the following information for each type of provider</i>):			
Provider Type:	License (<i>specify</i>):	Certificate (<i>specify</i>):	Other Standard (<i>specify</i>):
Employee in a self-directed arrangement			<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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and first aid • Staff that work with participants must have a high school diploma or high school equivalency (GED) • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Supervised by the employer of record or managing employer • For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A

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			<p>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</p> <ul style="list-style-type: none"> • State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by THE PIHP Medical Director or Assistant Medical Director • Agencies with Choice follow the NC State Nursing Board regulations • Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.
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 Services 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
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification:	
Self Employed	Employer of Record or Agency with Choice	Prior to hiring	

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Individual (self-directed only)	PIHP	Employer of Record Annually Agency with Choice as specified for a provider agency
Commercial/Retail Businesses	PIHP	Prior to first use
Financial Supports Agency	PIHP	Annually
Agency with Choice	PIHP	Annually
Service Delivery Method		
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

Service Specification	
Service Title:	Natural Supports Education
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" 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 type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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.</p>	
<u>Exclusions</u>	
<p>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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Reimbursement for conference and class attendance will be limited to \$1,000 per participant plan year.	
Provider Specifications	

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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:
	Employee in a self-directed arrangement		Provider Agencies enrolled in the PIHP Network	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Employee in a self-directed arrangement			<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"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health and safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Qualified Professional as specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Supervised by the employer of record or Managing Employer • State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by 	

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			<p>THE PIHP Medical Director or Assistant Medical Director.</p> <ul style="list-style-type: none"> • Agencies with Choice follow the NC State Nursing Board regulations. • Upon enrollment with THE PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP. Has expertise as appropriate in the field in which the training is provided in the ISP.
Provider Agencies			<p>Approved as a provider in THE PIHP provider network:</p> <ul style="list-style-type: none"> • Are at least 18 years old • If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health and safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and First Aid • Qualified Professional as specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP. • Upon enrollment with THE PIHP, the organization must have

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			<p>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.</p> <ul style="list-style-type: none"> Has expertise as appropriate in the field in which the training is provided in the ISP.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Employee in a self-directed arrangement	Employer of Record or Agency with Choice PIHP	Prior to hiring Employer of Record annually Agency with Choice as specified for Provider Agencies	
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Specialized Consultation
<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 checked="" type="checkbox"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Specialized consultation services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, physical therapy, occupational 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	

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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 ISP, 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 person centered planning team to participate in team meetings and provide additional intensive consultation and support for individuals 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

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Exclusions

Specialized consultation services exclude services provided through natural supports education and crisis services.

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

This service may not duplicate services provided to family members through natural supports education.

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:
	Independent Practitioners	Provider Agencies

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/>
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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>
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Independent Practitioner	Licensure specific to discipline, if applicable	Certification or registration specific to discipline, if applicable	<ul style="list-style-type: none"> • 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 • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Qualified in the customized need of the participants as described in the Individual Support Plan
Provider Agencies			<p>NC G.S.122C, as appropriate</p> <ul style="list-style-type: none"> • 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 • Criminal background check presents no health or safety risk to participant • Not listed in the North Carolina Health Care Abuse Registry • Qualified in the customized need of the participants as described in the Individual Support Plan

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Independent Practitioners	PIHP	At time of initial review and annually thereafter
Provider Agencies	Provider Agencies	Verifies employee qualifications at the time employee is hired

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PIHP		Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by THE PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Vehicle Modifications
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" 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 type="checkbox"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>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 itself. 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.</p> <p>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.</p> <p><u>Covered Modifications are:</u></p> <ol style="list-style-type: none"> (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 	

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- (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 participant's 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

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

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

Provider Specifications

Provider Category(s) Individual. List types: Agency. List the types of agencies:
 (check one or both): **Specialized Vendors** **Individuals** **Commercial/Retail Businesses**
 Specify whether the service may be provided by (check each that applies): Legally Responsible Person Relative/Legal Guardian

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

Provider Type:	License (specify):	Certificate (specify):	Other Standard (specify):
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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Specialized Vendors	PIHP	Prior to first use
Commercial/Retail Businesses	PIHP	Prior to first use

Service Delivery Method

Service Delivery Method (check each that applies): Participant-directed as specified in Appendix E Provider managed

Service Specification

Service Title: **Financial Support Services**

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

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.

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Service is not included in the approved waiver.

Service Definition (Scope):

Financial support services is the umbrella service for the continuum of supports offered to NC Innovations waiver participants who elect the individual and family directed services option, employer of record model. Financial support services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the employer.

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

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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 supports agency may provide Agency with Choice, community transition and individual goods and services as well as community guide services to the same participant.

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

Provider Specifications

Provider Category(s) Individual. List types: Agency. List the types of agencies:
 (check one or both):

Provider Agencies

Specify whether the service may be provided by (check each that applies): Legally Responsible Person Relative/Legal Guardian

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

Provider Type: License (specify): Certificate (specify): Other Standard (specify):

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 (IRS) to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6,
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Bonded

Meets all IRS requirements and be certified by the IRS as an employer agent

Understands the laws and rules that regulate the expenditure of public funds

Able to utilize accounting systems that operate effectively on a large scale, as well as track individual budgets

Able to develop, implement and maintain an effective payroll system that adheres to all related tax obligations, both payment and reporting

Able to conduct criminal and other required background checks

Able to generate service management and statistical information and reports during each payroll cycle

Have at least two years of basic accounting and payroll experience

Verification of Provider Qualifications

Provider Type:

Entity Responsible for Verification:

Frequency of Verification:

Provider Agency

PIHP

Upon initial approval and annually thereafter

Service Delivery Method

Service Delivery Method
(check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and (f) how participants are notified of the amount of the limit.

■	<p>Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i></p>
	<p>The following limits apply:</p> <ul style="list-style-type: none"> (1) Adult participants who receive residential supports: No more than 40 hours per week is authorized for any combination of community networking, day supports and/or supported employment services. (2) Child participants who receive residential supports: during the school year, no more than 20 hours per week is authorized for any combination of community networking, day supports and/or supported employment services. When school is not in session, up to 40 hours per week may be authorized. (3) Adult participants who live in private homes: No more than 84 hours per week is authorized for any combination of community networking, day supports, supported employment, personal care and/or in-home skill building. (4) Child participants who live in private homes: During the school year, no more than 54 hours per week is authorized for any combination of community networking, day supports, supported employment, personal care and/or in-home skill building. When school is not in session, up to 84 hours per week may be authorized. <p>Adult and child participants who live in private homes with intensive support needs: These participants may receive up to an additional 12 hours per day in-home intensive supports to allow for 24 hours per day of support with the prior approval of THE PIHP. For all services in the above sets of services in 1–4, if a person is getting only one service out of the set of services subject to a limit, the limit is applied to the one service received.</p>
■	<p>Budget Limit by Level of Support. 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><u>Transition to PIHP from the Comprehensive and Supports Waivers:</u> All current CAP-MR/DD Comprehensive and Supports waiver participants transitioning to NC Innovations have an individual budget that is a projection of the services and supports identified in the Individual Support Plan. The budget (cost</p>

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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 CAP-MR/DD budget amount will become the new individual budget amount once transitioned to the PIHP. The NC Innovations waiver will not include the current targeted Case Management service; Treatment Planning case management will be provided by Care Coordinators.

The newly transitioned individual budgets will be used until the needed Supports Intensity Scale assessments and Support Needs Matrix category budgets can be developed which is anticipated to take a minimum of 24 months. During this transition, the individual budget will reflect base budget services and non base budget services, in combination not to exceed the \$135,000 cost limit, as an educational tool to prepare for transition to the Support Needs Matrix.

Waiver participants in the original PBH geographic area:

All waiver participants are assigned to a Support Needs Matrix category on either the Residential Support Needs Matrix or the Non-Residential Support Needs Matrix (collectively referred to as the “Support Needs Matrix”). The Residential Support Needs Matrix is applied to those individuals that require residential services and the Non-Residential Support Needs Matrix is applied to those individuals that do not require residential services.

Basis of the Budget Limit:

The Support Needs Matrix is designed to standardize funding among persons who have similar support (acuity) needs and reflects: assessment derived categories of need, age, and budget limit.

The assessment instrument used to objectively measure individual support needs is the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Intellectual Disabilities and Developmental Disabilities (AAID). The SIS is a valid, reliable instrument for assessing the level of an individual’s support needs in major domains of daily living as well as behavioral and medical needs. The SIS has been in use by the original demonstration PIHP, PBH, 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 a dedicated team of local SIS interviewers has been successfully completed by two of the SIS authors. This training included both the adult version of the SIS and the child version of the SIS. The SIS has been enhanced by supplemental questions that include four topics: community safety risk (convicted and not convicted), extreme self-injury risk, and extraordinary medical care (risk) for individuals whose supervision for those concerns requires 24 hour eyes on supervision.

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

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The specific categories 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 category of need algorithm used by these other jurisdictions have satisfactorily explained differences in funding authorizations that stem from differences in objectively assessed support needs.

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

The budget limit for each cell of the Support Needs Matrix were developed based on an analysis of historical expenditures of the “Base Budget Services” for individuals participating in NC Innovations, guideline service packages and provider rates paid by THE PIHP.

The most recent local SIS interviews from the previous calendar year are made into SIS informed categories 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 categories on July 1 of each year beginning in 2010. The Support Needs Matrix will be phased in as resources permit during a period not to exceed three years. At the end of the three years the Support Needs Matrix will be applicable for all waiver participants.

Services Included in the Support Need Matrix:

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

1. Community Networking Services
2. Day Supports
3. In-Home Skill Building,
4. Intensive In-Home Supports
5. Personal Care
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 Guide Services
3. Community Transition Services
4. Crisis Services
5. Financial Support Services
6. Individual Goods and Services
7. Home Modifications
8. Natural Supports Education

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9. Specialized Consultation Services

10. Vehicle Modifications

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

Individual Budget:

The budget limits in the Support Needs Matrix are the maximum Individual Budget amount that can be authorized for Base services in a waiver participant’s Individual Support Plan.

The Care Coordinator (Case Manager), as part of the Individual Support Plan development, will explain the Support Needs 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.

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

In developing the Individual Support Plan and the Individual Budget, the planning team will be guided by the person’s support needs as identified in the SIS assessment and their selection of living arrangement. The person’s support needs and their living arrangement will be used to identify the category of need assigned to the participant and the cost limit associated with that category of need in the Support Needs Matrix. The strength of the Support Needs Matrix is that each individuals’ identified category is based on their assessed support needs and community living arrangement choice. The Care Coordinator will guide the development of the Individual Support Plan, based on assessed need and living arrangement, such that the resulting Individual budget for “Base Budget Services” is at or below the appropriate cost limit in the Support Needs Matrix.

Adjustments for Individual Circumstances:

The Care Coordinator will call an ISP 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 Utilization Management Department or designee may approve a time limited, temporary, (not to exceed six months) increase in intensity of services. Temporary increases are unplanned/unexpected circumstances that change the participant’s support needs for a time-limited period.

If the interdisciplinary team determines that a waiver participant has an extended need for an increased intensity of supports needs, this will be considered a permanent support needs, (beyond six months), the individual may be authorized a change in living

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arrangement (from home to a community based residential facility or from a community based residential facility to home) which will move the participant between the Non-Residential Support Needs Matrix and the Residential Support Needs Matrix; or the participant may be re-assessed and, if supported by the results of a new SIS assessment, moved to a higher category of support need. If the cost limits in the new living arrangement or category of support need will not meet the participant's support needs, the participant may seek approval for placement in the Intensive Review Category.

If the Individual Budget and Individual Support Plan cannot be developed for Base Budget Services at or below the Budget limit, the Care Coordinator will prepare a justification for placement of the participant into the Intensive Review Category 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 Support Need Matrix cell) and request review by the *Intensive Review Committee* prior to submission of the Individual Support Plan and the Individual Budget to THE PIHP Utilization Management Department.

If the *Intensive Review Committee* determines that the support needs for the participant requesting placement into Intensive Review category that fall significantly outside usual and customary support needs for their assigned category, the participant will be included in Intensive Review and the Individual Budget developed by the planning team will be approved.

Adjustments to the Budget Limits in the Support Need Matrix:

The Budget limits in the Support Needs 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 Support Needs 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 Support Needs 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 categories of need in the Support Needs 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 Support Needs 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 NC Innovations Waiver.

Availability of Methodology:

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A description of the methodology used by the other jurisdictions to develop the categories of need algorithm is available to CMS upon request. The methodology for determining the Support Needs Matrix is available for public review and inspection upon request from THE PIHP.

Participant Safeguards:

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

If the Support Needs Matrix category budget and the Individual Support Plan cannot be developed for Base Budget Services at or below the cost limit, the Care Coordinator will prepare a justification for placement of the participant into Intensive Review 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 Support Need Matrix category) and request review by the *Intensive Review Committee* prior to submission of the Individual Support Plan and the Individual Category Budget to THE PIHP Utilization Management Department.

If the *Intensive Review Committee* determines that the support needs for the participant requesting placement into Intensive Review fall significantly outside usual and customary support needs, the participant will be included in the Intensive Review category and the Support Need Matrix Category Budget developed by the planning team will be approved.

If a participant’s support needs cannot be met through a time limited (temporary) increase in intensity of services, a movement from the Non-Residential Support Needs Matrix to the Residential Support Needs Matrix or has not been approved for placement into the Intensive Review category the participant will be referred to an ICF/MR facility.

The individual and their planning team will create a new, person focused Individual Support plan supported by the new Support Needs Matrix funding category. This is in line with the individual’s pursuit of self-direction and a life integrated in their local community.

As reported in Appendix B-2 Individual Cost Limit, the participant will be referred to an ICF-MR as their care cannot be met within the \$135,000 cost limit.

Transition to PIHP from the Comprehensive and Supports Waivers:

Comprehensive and Supports waiver participants will use their current CAP-MR/DD budgets to ensure a seamless transition into the NC Innovations waiver until the needed SIS assessments and Support Needs Matrix category budgets can be developed.

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

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title: **NC Innovations Individual Support Plan (ISP)**

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the state
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under state law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case manager (qualifications specified in Appendix C-3)
<input checked="" type="checkbox"/>	Case manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i> Qualified professional as defined in NC G.S.-122 C A Qualified professional is equivalent to the federally defined qualified mental retardation professional.
<input type="checkbox"/>	Social worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

b. Service Plan Development Safeguards. *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) A variety of person centered toolkits are available to gather information and enable the participants to share information with the ISP team. The participant can complete the toolkit with the assistance of the care coordinator or support providers as needed. Based on the unique needs of the participant, a decision can be made to use one toolkit, multiple

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toolkits or none at all.

(b) The participant and care coordinator review the team composition to make sure that people the participant would like to have at the meeting are invited. If the participant has a legally responsible person, the care coordinator will ensure that the person is invited to the ISP meeting as well.

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

Individual Support Plan (ISP)

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

At the time the participant enters the waiver, information is shared with the recipient regarding the NC Innovations waiver. The participant's care coordinator is available to answer any questions that the participant/family may have regarding available services. The care coordinator works with the participant/family to develop the ISP. That care coordinator determines with the participant and/or legally responsible person to what degree they desire to lead the planning team and to identify the membership of the team. In addition to the participant, parents, legal guardians, and care coordinator, additional planning team members may include: support providers, family friends, acquaintances and other community members. The ISP is developed face to face with the waiver participant and legally responsible person at a minimum.

The initial ISP, with an authorized signature(s), is completed and submitted to THE PIHP for approval no later than 60 days from the approval of the NC Innovations Level of Care tool. Annual plans, with an authorized signature(s), are developed to be effective the first day of the month following the participant's birth month.

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Assessments

A variety of assessments are completed to support the planning process including:

Person Centered Information: This involves identifying what is most important to the participant from their perspective and the perspective of others that care about the participant. It involves identifying the participant's strengths, preferences and needs through both informal and formal assessment process. A variety of person centered tool kits are available to assist in getting to know the participant. These toolkits include worksheets, workbooks and exercises that can be completed by the participant, with the assistance of the care coordinator or other support persons as needed.

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

Information about Support Needs: This information assists in assuring that the participant receives needed services, and at the same time, that participants do not receive services that are unnecessary, ineffective and/or do not effectively address the participant's identified needs. This can include information from the Supports Intensity Scale (SIS), health/support assessment and/or other formal assessment of the participant's support needs.

Additional Formal Evaluations: These are evaluations by professionals and can include physical therapy, occupational therapy, speech therapy, vocational, behavioral, developmental testing, physician recommendations, psychological testing, adaptive behavior scales or other evaluations as needed.

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

Prior to the Person Centered Planning Meeting:

The care coordinator offers the participant/legally responsible person information about Individual Family Supports. If the participant/legally responsible person is interested in learning more about individual/family directed supports, the care coordinator arranges for them to receive additional training and information.

The care coordinator informs the participant/legally responsible person of the participant's individual budget amount and answers any questions regarding the budget. The care coordinator also provides the amount of the self-directed budget if the participant/legally responsible person desires to self-direct one or more services.

The care coordinator supports the participant to schedule the meeting and invite team members to the meeting at a time and location that is desirable for the participant.

The Individual Support Planning Meeting

The participant and care coordinator review with the team all issues that were identified during the assessment processes. Information is presented in draft plan form. Information is organized in a way that allows the participant to work with the team and have open discussion regarding

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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 members 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 community supports, may be assigned monitoring responsibilities.

Individual Support Plan Development

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

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

The ISP is updated annually, however if the participant's provider changes or needs change and requires services to be added, increased, decreased or terminated, a revision to the plan shall be completed and submitted to THE PIHP utilization management for approval. The care coordinator reassesses each participant's needs at least annually and develops an updated PCPISP continued need review (CNR), based on that reassessment. The care coordinator will follow-up and resolve any issues related to the participant's health, safety or service delivery. Unresolved issues will be brought to the attention of THE PIHP and provider agency by the care coordinator to resolve these issues.

The care coordinator will provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. In the event the ISP developed results in denial of services, the care coordinator will inform the participant of the right to request a fair hearing. The care coordinator will assist the participant and the family through the Fair Hearing process. The care coordinator will inform the participants of grievance and complaint resolution processes. This information will be provided on an annual basis during the annual ISP process.

Also as part of the annual review, the care coordinator, in consultation with the participant and

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the team, will identify the Most Integrated Setting appropriate in which to provide the individual for supports and services. If the Most Integrated Setting is not available, the care coordinator will document in the individual's file the supports and services needed to achieve the Most Integrated Setting, as well as the obstacles and barriers in achieving the Most Integrated Setting.

The ISP will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who will furnish each service or support. A Crisis Prevention Plan is incorporated within the ISP. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably. The Crisis Prevention Plan should include what positive skills the participant has which can be elicited and increased at times of crisis; how to implement redirection of energies towards exercising these skills that can prevent crisis escalation; how to implement positive behavioral supports that may be relied upon as a crisis response. The Crisis Prevention Plan is an active and living document that is to be used in the event of a crisis. After crisis, the participant and staff should meet to discuss how well the plan worked and make changes as indicated.

The ISP also includes other formal and informal services and supports that the participant wants and/or needs. The ISP provides for supports and coordination for the participant to access school based services, generic community resources and Medicaid state plan services. The care coordinator makes sure that the ISP contains a plan for coordinating services, including the care coordinator's responsibility for overall plan coordination of waiver and other services.

The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Care coordinators will work with participants to identify potential sources of services and support; paid and non paid natural supports within their catchment areas. Also, THE PIHP will ensure that participants eligible for Medicaid will have freedom of choice of qualified providers. The process for review and approval/authorization of participant ISPs is a primary function of THE PIHP.

All initial/annual/plan updates require an authorized signature(s).

THE PIHP
Plan Approval

The ISP approval process by THE PIHP verifies that there is a proper match between the participant's needs and the service provided. 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.

The care coordinators developing the plan are employees of THE PIHP in a separate unit from the individuals authorizing the plan. The care coordinator may not exercise prior authorization

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authority over the individual support plan.

THE PIHP will not approve an ISP that exceeds the limitations in any individual service definition, for the sets of services found at C-4 or the individual's service budget.

Updates/Changes to the PCPISP

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

Transition to the New Waiver

The current approved ISP for each participant of the Comprehensive and Supports waiver will continue to be used until the next annual SP development at the participant's birth month. All services currently used under that waiver (or an equivalent service) are available in the NC Innovations waiver after this modification. Please note the following differences:

Service Under Comprehensive Waivers	Supports/	Service Name Under Innovations Waiver
Adult Day Health		Included in Day Supports
Behavior Consultation		Specialized Consultation, Crisis Services
Home and Community Supports		In-Home Skill Building Intensive In-Home Support Community Networking
Individual Caregiver Training and Education		Natural Supports Education
Long Term Vocational Supports		Included in Supported Employment
Personal Care		Included in the waiver
Personal Emergency Response System		Included in Assistive Technology Equipment and Supplies
Non-Medical Transportation		Community Networking transportation

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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The NC Innovations Risk/ Support Needs Assessment is completed prior to the development of the ISP and updated as significant changes occur with the participant at least annually. The care coordinator works with the participant, family and other team members to complete the assessment.

1. The NC Innovations Risk/Support needs assessment includes: health and wellness screening to include the primary care physician to act as the locus of coordination for all health care issues, medication management, nutrition, preventive screenings, as appropriate, and any relevant information obtained from other supports needs assessments.
2. Risk screening to include behavioral supports, potential mental health issues, personal safety and environmental community risk issues.

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Support needs and potential risks that are identified during the assessment process are addressed in the ISP, which includes a crisis plan as applicable. Strategies to mitigate the risk reflect participant needs and include consideration of the participant preferences. Strategies to mitigate risk may include the use of risk agreements.

The ISP states how risks will be monitored and by whom, including the paid providers, natural and community supports, participants and their family and the care coordinator.

A backup staffing plan is included in the ISP and designed to meet the needs of participants to make sure that their health and safety is ensured. It outlines who (whether natural or paid) is available, contact numbers, at least two levels of backup staffing are identified for each waiver service provided.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about, and selecting among, qualified providers of the waiver services in the service plan.

The care coordinator, following THE PIHP policy, assists the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP. The care coordinator meets with the participant/legally responsible person and provides them with a provider listing of each qualified provider within THE PIHP provider network and encourages the individual/legally responsible person to select providers that they would like to meet to obtain further information. The 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. Once the participant has selected a provider, their choice of provider is documented in the service record.

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

THE PIHP approves ISPs following a process approved by the DMA, the State Medicaid agency. The care coordinators developing the plan are employed by THE PIHP in a separate unit from the individuals authorizing the plan. ISP approval occurs locally at THE PIHP. DMA authorizes THE PIHP to approve ISPs through routine monitoring of the plan of care 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 plan of care approval would be carried out by DMA or DMA designee.

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h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

<input type="checkbox"/>	Every three months or more frequently when necessary
<input type="checkbox"/>	Every six months or more frequently when necessary
<input checked="" type="checkbox"/>	Every twelve months or more frequently when necessary
<input type="checkbox"/>	Other schedule (<i>specify</i>):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	PIHP

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Appendix D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and (c) the frequency with which monitoring is performed.

The care coordinator in the THE PIHP care coordination unit is responsible for monitoring the implementation of the ISP. Services are implemented within 45 days of ISP approval. The care coordinator is responsible for the monitoring of activities. Monitoring will take place in all service settings and on a schedule outlined in the ISP.

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

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

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Care coordinator monitoring occurs monthly to include the following:

- (1) 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 safety needs.
- (2) Participants whose services are provided by guardians and relatives living in the home of the participant receive monthly face-to-face monitoring visits.
- (3) Participants who live in residential programs receive face-to-face monitoring visits monthly.
- (4) Participants who choose the individual family directed service option receive face-to-face monitoring visits monthly.
- (5) 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.
- (6) At least one service is utilized monthly, per waiver eligibility requirements.
- (7) That services utilized do not exceed authorization. If there is an emergency, the care coordinator should ensure that enrollee needs are met and ensure that any updates to the LOC and ISP, based upon the changes in needs of the individual, are processed in a timely manner.

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- b. **Monitoring Safeguards.** *Select one:*

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

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Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Quality Management: Service Plan

As a distinct component of the State’s quality management strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a Methods for Discovery: **Service Plan Assurance/Subassurances**

a.i.a Sub-Assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	<i>Proportion of ISP in which the services and supports reflect participant assessed needs and life goals</i>		
Data Source Person Centered Plan Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other(Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other(Specify):	
			<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Proportion of ISPs that address identified health and safety risk factors</i>		
Data Source ISP Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-Annually	

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Performance Measure:	<i>Proportion of participants reporting that their ISP has the services that they need</i>		
Data Source ISP Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

a.i.b Sub-assurance: The State monitors service plan development in accordance with the approved waiver and takes appropriate action when it identifies inadequacies in service plan development.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

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Performance Measure:	<i>The State requires THE PIHP to report results of performance measures related to the service plan to DMA and the Intra-Departmental Monitoring Team (IMT) and requires corrective action as appropriate. Corrective action is monitored at minimum quarterly by DMA and the IMT.</i>		
Data Source PIHP reports on service plan performance measures	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly (Corrective action plan monitoring)	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-Annually (Reporting on measures by PIHP)	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section

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provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	<i>Proportion of individuals whose needs change during the year for whom an appropriate plan update took place</i>		
Data Source ISP Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	ISP update
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Timeliness of Initial Service Delivery. The average amount of time from C waiver services level of care determination to approval for initiation of services, the average amount of time from approval for initiation of services to plan service development to implementation of direct care services.</i>		
Data Source ISP Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	ISP update

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	Agency		
	■ Other (Specify):	■ Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	■ Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	■ Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	■ Other (Specify):	■ Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval		
Data Source Person Centered Plan Record Reviews Financial records	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	■ Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management	■ Quarterly	

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	Agency		
	■ Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	■ Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	■ Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	■ Other (Specify):	<input type="checkbox"/> Annually	
	PIHP	■ Other (Specify):	
		Annually	

Performance Measure:	<i>Proportion of waiver participants who are receiving services in the type, scope, amount, and frequency as specified in the ISP</i>		
Data Source Person Centered Plan Record Reviews Financial records	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	■ Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	■ Quarterly	
	■ Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	■ Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	■ Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify

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	<input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Other (Specify):</i> Semi Annually	

a.i.e Participants are afforded choice: between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	<i>Proportion of records that contain a signed freedom of choice statement</i>		
Data Source Record Review PIHP Consumer Files	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
		<input type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other: Specify</i>
	<input checked="" type="checkbox"/> <i>Other (Specify):</i> THE PIHP	<input checked="" type="checkbox"/> <i>Annually</i>	
		<input type="checkbox"/> <i>Other (Specify):</i>	

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Performance Measure:	<i>Proportion of participants reporting their care coordinator helps them to know what waiver services are available</i>		
Data Source Person Centered Plan Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Timeliness of Initial Service Delivery. The proportion of Medicaid enrollees discharged from institutional care in an ICF-MR into the community through the use of waiver funding.</i>		
	Performance Measure:	<i>Proportion of participants reporting that they have a choice between providers</i>	
	Data Source Person Centered Plan Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):
		<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
			<input checked="" type="checkbox"/> Representative Sample with

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				<i>confidence interval of 95%</i>
		<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
		<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
		<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		THE PIHP	<input type="checkbox"/> Other (Specify):	
				<input type="checkbox"/> Other: Describe
Data Source ISP Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review	
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	ISP update	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group	
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):		
		semiannually	<input type="checkbox"/> Other: Describe	
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report	
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation	
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify	
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually		
	THE PIHP	<input type="checkbox"/> Other (Specify):		

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

N/A

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b. Methods for Remediation

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

THE PIHP will address and correct problems identified on a case-by-case basis and include the information in the report to DMA and the Intra-departmental Monitoring Team. DMA may require a corrective action plan if the problems identified appear to require a change in THE PIHP's processes for developing, implementing and monitoring service plans. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

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Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input checked="" type="checkbox"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="checkbox"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

<input checked="" type="checkbox"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="checkbox"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

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

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

Both models of individual and family directed supports (Employer of Record and Agency With Choice) will be available in the PBH area and in the PBH expansion counties. In the other PIHP'S, the Agency With Choice Model will be initially offered. The Employer of Record Model will be available in other PIHP's no later than one year from the date of transition to NC Innovations. PIHP's 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 documents and a plan that demonstrates that contracted Community Guide Agencies have or will be trained by the proposed implementation date. DMA will approve implementation plans prior to implementation

Comment [A1]: Include anything about phasing in employer of record?

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date. The Intra Departmental Monitoring Team will provide oversight in the implementation of Individual and Family Directed Supports.

All waiver participants are offered the opportunity to direct one or more of the following services: community guide services; community networking services; in-home supports; intensive in-home supports, individual goods and services; natural support education; respite services; personal care and supported employment services. The participant may direct one or all of these services, and may receive additional provider directed services that the participant does not choose to self-direct.

Participants are offered an opportunity to receive an orientation to individual and family directed supports meeting from the care coordinator at the time of the initial or annual plan. The orientation consists of information presented by the care coordinator. The care coordinator informs participants that additional training on individual and family directed services is available from a community guide. The community guide is a provider that assists participants in locating and coordinating community resources and with direct assistance in participant direction activities. The care coordinator includes community guide services in the ISP as directed by participants. Community guide services for the purpose of training and support in implementing individual and family directed supports are available to participants without charge to the individual budget.

When a participant and/or legally responsible person expresses interest in directing services, they receive additional training from a community guide. The community guide also provides the participant/legally responsible person with a copy of an employer handbook and other educational materials. The training and educational materials provide sufficient information to ensure that the participant and/or legally responsible person make informed choices about the degree they wish to self-direct services.

After the training, the participant and/or legally responsible person meets with a care coordinator. The employer of record or managing employer is identified. The employer of record or managing employer is the participant, the parent of a minor participant or the guardian of the participant. If a representative is desired or needed to assist in directing services, the care coordinator assists in the appointment of the representative. The care coordinator assesses the employer of record, managing employer, and representative, if applicable, to determine the areas of support needed to self-direct services. Standard assessment tools are used with each employer, managing employer and/or representative.

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

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

Once the ISP is approved, a referral is made to a financial supports agency for participants who have elected the employer of record model. The financial supports agency assists by assuring

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that services are managed and funds distributed as needed. The financial supports agency also assists with required paperwork that is submitted to the Internal and State Revenue Services, and facilitates the employment of support staff. The employer of record screens, hires, and trains staff. The employer of record manages the individual and family directed (participant-directed) budget by setting employee pay rates and benefits through the use of a computer based auto calculator. Community guides are able to assist employers who do not have access to computers with the auto calculator and other web-based resources. The employer of record provides the supervision of the staff in lieu of supervision that would normally be provided by a qualified professional in a provider directed employment arrangement. If necessary, the employer dismisses employees.

For participants who elect the agency with choice model, a referral is made to an agency with choice. The agency with choice serves as the common law employer for employees providing services to the participant. The managing employer screens, interviews and recommends applicants for hire. Managing employers and the agency with choice jointly ensure that employees are trained. The managing employer provides supervision of staff with oversight by a qualified professional employed by the agency with choice. If necessary, the managing employer dismisses or recommends dismissal of employees.

In both models, agreements with THE PIHP, the financial supports agency, agency with choice and employees outline responsibilities of all parties in the individual and family directed support option. Community guides assist the employer or managing employer with employer duties and responsibilities as requested or needed. Participants in either model of individual and family directed supports have access to individual goods and services when employees begin work.

THE PIHP provides ongoing support for individual and family directed supports by maintaining a website with information about individual and family directed supports. THE PIHP also arrange periodic meetings for employers and managing employers that provide opportunities for meetings with key support agencies, including care coordinators, community guides, agencies with choice and financial supports agencies.

THE PIHP monitor individual and family directed supports by annual monitoring of participants in individual and family directed supports, and financial supports agency. Community guide agencies and agencies with choice are monitored at least once every three years at a frequency determined by THE PIHP. Participants in individual and family directed supports may elect to return to provider directed services at any time by informing the care coordinator. THE PIHP may remove a participant from individual and family supports, after consultation with the DMA, in instances when the participant's health and safety are compromised, or after an employer or managing employer has made the same major mistake three different times in one year.

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

- Participant – Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the agency with choice of workers. Supports and protections are available for participants who exercise

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	this authority.
<input type="checkbox"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="checkbox"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>): Participants that live in facilities larger than three beds have the option to direct their community guide, community networking, and supported employment services.

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

<input type="checkbox"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="checkbox"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="checkbox"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

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

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

If the participant/legally responsible person is interested in electing one of the individual/family directed models, they will receive training on the roles and responsibilities, and the advantages and potential liabilities of participation in the option and each model. The Community Guide

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Agency is responsible for training and provision of educational materials to include the employer handbook and resource materials at the time of training. If the participant has chosen one of the two models of individual/family directed supports, they will receive ongoing training per specified areas in their ISP.

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

<input type="checkbox"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="checkbox"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	<p>Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>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 of record or managing employer. That person 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 voluntary representative may still 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 participant is unable to perform.</p> <p>The representative must meet the following requirements:</p> <ol style="list-style-type: none"> 1. Demonstrate knowledge and understanding of the participant’s needs and preferences and respect these preferences 2. 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 3. Agree to a predetermined level of contact with the participant 4. Be at least 18 years of age 5. Be willing and able to comply with program requirements, be approved by the participant or his/her legal representative to act in this capacity <p>The representative may not:</p> <ol style="list-style-type: none"> 1. Be paid for being the representative 2. Provide paid services to the participant, including employees of agencies providing services, with the exception of guardianship services 3. Have a history of physical, mental or financial abuse

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. (*Check the opportunity or opportunities available for each service*):

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Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Guide	■	■
Community Networking	■	■
In-home Skill Building	■	■
Individual Goods and Services	■	■
Natural Support Education	■	■
Respite	■	■
Personal Care	■	■
Supported Employment	■	■
In-home intensive supports	■	■

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

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

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

<input checked="" type="radio"/>	FMS are covered as the waiver service entitled Financial Support Services as specified in Appendix C-3. <i>Provide the following information:</i>
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Agencies under contract with and approved by THE PIHP who meet the qualifications for Financial Supports listed in Appendix C. THE PIHP uses a standardized process to request information or proposals from provider agencies within the provider network who may have interest or expertise in providing these services.
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: THE PIHP sets rates for the Financial Support Service by analyzing the cost of the tasks the Financial Supports Agency is required to perform and the frequency these activities are performed. A monthly rate is established with the Financial Support Agency billing the actual cost of start-up costs (initial employee training, initial supplies, etc.).

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iii.	<p>Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):</p> <p><i>Supports furnished when the participant is the employer of direct support workers:</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"><input checked="" type="checkbox"/></td><td>Assist participant in verifying support worker citizenship status</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Collect and process timesheets of support workers</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Other (<i>specify</i>):</td></tr> <tr><td colspan="2" style="text-align: center;">Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record</td></tr> </table> <p><i>Supports furnished when the participant exercises budget authority:</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"><input checked="" type="checkbox"/></td><td>Maintain a separate account for each participant's participant-directed budget</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Track and report participant funds, disbursements and the balance-of participant funds</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Process and pay invoices for goods and services approved in the service plan</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Provide participant with periodic reports of expenditures and the status of the participant-directed budget</td></tr> <tr><td><input type="checkbox"/></td><td>Other services and supports (<i>specify</i>):</td></tr> <tr><td colspan="2" style="height: 20px;"></td></tr> </table> <p><i>Additional functions/activities:</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"><input type="checkbox"/></td><td>Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget</td></tr> <tr><td><input type="checkbox"/></td><td>Other (<i>specify</i>):</td></tr> <tr><td colspan="2" style="height: 20px;"></td></tr> </table>	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	<input checked="" type="checkbox"/>	Other (<i>specify</i>):	Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record		<input checked="" type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget	<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds	<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan	<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget	<input type="checkbox"/>	Other services and supports (<i>specify</i>):			<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency	<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	<input checked="" type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget	<input type="checkbox"/>	Other (<i>specify</i>):		
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status																																
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers																																
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance																																
<input checked="" type="checkbox"/>	Other (<i>specify</i>):																																
Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record																																	
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<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency																																
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency																																
<input checked="" type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget																																
<input type="checkbox"/>	Other (<i>specify</i>):																																
iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>The Financial Supports Agencies are monitored at least annually by THE PIHP. An instrument developed by the PIHP is used to review all financial supports agency responsibilities and systems. In addition, THE PIHP monitor incidents and complaints that are submitted. The Financial Supports Agency is required to maintain a complaint log and conduct satisfaction surveys. The results of the complaint logs and satisfaction surveys are submitted to THE PIHP.</p>																																

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available

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to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p> <p>Care coordinators provide basic support to all individuals receiving participant-directed services. Participants are offered the opportunity to receive an orientation regarding self-directed care at the time of the initial ISP development. The care coordinator informs participants that training on individual and family directed services is available from a community guide. The care coordinator assists with the development of the ISP, including any self-directed services. Finally, the care coordinator monitors the implementation of the ISP.</p>
<input checked="" type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Community Guide</p>
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:</i></p>

k. Independent Advocacy (*select one*).

<input checked="" type="checkbox"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>Independent Advocacy is available through advocacy organizations. Participants are notified upon entry to the waiver of the availability of self-referral to an advocacy organization, and how to contact THE PIHP. Care coordinators and community guides are also able to assist participants and families in obtaining independent advocacy services.</p>
<input type="checkbox"/>	<p>No. Arrangements have not been made for independent advocacy.</p>

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

<p>A participant in individual and family directed supports may withdraw from the option at any time by notifying the care coordinator. The care coordinator prepares a revision to the ISP, and submits the revision to THE PIHP, so that provider directed services are authorized for the participant with no service lapse. The following steps are followed:</p> <p>(1) Employer or managing employer requests that the care coordinator terminate individual</p>
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- and family directed services option, and return the participant to provider-directed services.
- (2) Care coordinator asks the employer or managing employer to select a provider and updates the ISP to reflect termination of individual and family directed services and the provider agency selected by the employer or managing employer to provide provider-directed services.
 - (3) The legally responsible person signs the ISP, and the care coordinator submits it to THE PIHP for approval.
 - (4) THE PIHP approves the ISP, authorizes provider-directed services and terminates financial supports services.
 - (5) THE PIHP sends a letter to the legally responsible person, financial supports services and community guide and agency with choice notifying them of the termination of individual and family directed services per the legally responsible person's request the date of the termination of payroll to employees. The letter is copied to the care coordinator and DMA.
 - (6) The employer of record or agency with choice model notifies staff that they are no longer employed under the individual and family directed services option.
 - (7) The Finance Department reconciles the individual budget with the Financial Services Agency. Any non-used funds are returned to THE PIHP by the Financial Services Agency.

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- m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A participant in individual and family directed supports may be removed from individual and family directed services involuntarily under the following circumstances:

- (1) Immediate health and safety concern, including maltreatment of the participant
- (2) Repeated unapproved expenditures/misuse of NC Innovations funds
- (3) No approved representative available when the employer of record/managing employer in the Agency with Choice Option is determined to need one
- (4) Refusal to accept the necessary community guide services
- (5) Refusal to allow care coordinator to monitor services
- (6) Refusal to participate in PIHP, state or federal monitoring
- (7) Non-compliance with individual and family supports, financial support services, agency with choice and/or employee support agreements
- (8) Inability to implement the approved ISP or comply with Cardinal Innovations requirements, despite reasonable efforts to provide additional technical assistance and support (for event requiring additional technical assistance/corrective action plan in twelve months).

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Normally, employers or managing employers in individual and family directed supports are terminated from the individual and family directed services option if the same major mistake occurs more than three times in a twelve month period. However, the recommendation can occur at any point when the participant's health and safety are at risk or misuse of funds is suspected. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to ensure health and safety. If it is determined at any point in THE PIHP investigation that the person immediately needs to be returned to the provider directed option to ensure their health and safety, this can be recommended. The following steps are followed:

- (1) Concerns and/or allegations of major problems with the implementation of individual and

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family directed supports are reported to each PIHP.

- (2) THE PIHP consultant investigates the concerns or allegations of major problems. The consultant will review all available plans of correction and documentation.
- (3) Depending on results of the investigation, the consultant may recommend termination of individual and family directed services. If the removal is an emergency, THE PIHP or the care coordinator, contacts the Office of the Medical Director and obtains a decision regarding removal. This decision is reported to DMA the first working day following the removal.
- (4) Termination from the individual and family directed services option is normally at the end of a month; however, when the termination is due to a threat to the participant's health and safety, such as physical abuse, termination should occur immediately, and provider-directed services should resume immediately.
- (5) If the employer/Agency with Choice disagrees with the decision of THE PIHP/DMA, the employer/Agency with Choice may file a reconsideration request or a grievance.
- (6) Steps 2 through 6 of the voluntary termination procedure are followed to return the participant to the provider-directed supports option.

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- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
Waiver Year	Employer Authority Only Number of Participants	Budget Authority Only or Budget Authority in Combination with Employer Authority Number of Participants
Year 1		288
Year 2		288
Year 3		288
Year 4 (renewal only)		288
Year 5 (renewal only)		288

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Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. Participant Employer Status. Specify the participant’s employer status under the waiver. Check each that applies:

<input checked="" type="checkbox"/>	<p>Participant/Agency with Choice. The participant (or the participant’s representative) functions as the Agency with Choice (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as Agency with Choices of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:</i></p> <p>Agencies with choice are provider agencies who meet the qualifications for service delivery of all NC Innovations services that may be directed under the individual and family supports option. THE PIHP requires specific assurances that are included in each provider agency’s contract that require the agency with choice to maintain policies and procedures that support the control and oversight by participants and/or managing employers over employees. These policies and procedures are subject to approval by THE PIHP. Agencies with choice must attend PIHP-sponsored trainings and participant/family meetings in individual and family directed supports.</p>
<input checked="" type="checkbox"/>	<p>Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

ii. Participant Decision Making Authority. The participant (or the participant’s representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

<input checked="" type="checkbox"/>	Recruit staff
<input checked="" type="checkbox"/>	Refer staff to agency for hiring (Agency with Choice)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Component part of Financial Support Services; conducted by Agency with Choice for all applicants referred by the Managing Employer and compensated by service rate
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits (common law employer)
<input checked="" type="checkbox"/>	Schedule staff

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<input type="checkbox"/>	Orient and instruct-staff in duties
<input type="checkbox"/>	Supervise staff
<input type="checkbox"/>	Evaluate staff performance
<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (Agency with Choice)
<input type="checkbox"/>	Other (<i>specify</i>):

b. Participant – Budget Authority (*Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b*)

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input type="checkbox"/>	Reallocate funds among services included in the budget with prior approval of THE PIHP
<input type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each participant in this waiver has an individual budget. The budgeting methodology is described in Appendix C-4. Participants have the authority to request and have approved services that meet the participant’s needs within that budget. They may request budget modifications based on new or one time needs as described in the individual budgeting methodology. In addition the employer or managing employer may set aside up to \$2,000 per year to purchase individual goods and services. Individual budget modifications

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require the prior approval of THE PIHP. Information about the individual and family directed budget is provided in the employer handbook and in additional handouts provided during individual and family directed supports training.

The participant-directed budget is known as the individual and family directed supports budget and is a component of the individual budget. It consists of the total dollar amount of individual and family directed services, at the individual and family directed supports rate.

In the employer of record model, the individual and family directed services rates are set by THE PIHP and are the established hourly service rates for provider directed services rates minus an administrative rate established to cover the costs of financial support services, forms and supplies provided to employers of record and start-up costs for employers (blood-borne pathogen supplies, first aid kits, employment ads, background checks, initial employee training, etc.). The employer is provided with an auto-calculator that assists in managing the individual and family directed budget. The employer has the authority to establish employee pay rates and benefits. Additionally, the employer budgets and directs payment for workers compensation insurance, employment taxes, additional employee training, habilitation training supplies, back-up staffing and other items that are directly related to the cost of providing services. The community guide trains the employer in the use of the auto-calculator and provides alternative methods for budgeting if the employer does not have access to a computer. The financial supports agency establishes procedures for managing participant funds and provides the employer of record with a monthly report of revenues (service billing) and expenditures (services provided). The procedures and format for the monthly report are subject to the approval of THE PIHP.

In the agency with choice model, the established hourly service rate is the same as the rate paid to the provider agency to deliver NC Innovations waiver services. The service rate includes the cost of employee pay rates, employment taxes, workers compensation insurance, employee benefits, forms, supplies, start-up costs to include first aid kits, employment ads, initial and on-going employee training, criminal and other background checks, first aid supplies, employment ads, habilitation training supplies, qualified professional oversight, maintenance of records, back-up staffing and other items directly related to the cost of providing services. The agency with choice establishes procedures for managing participant funds and assists managing employers in budgeting the individual and family directed budget. The agency with choice also provides a quarterly report of revenue (service billing) and expenditures to the managing employer. The procedures and format for the quarterly report are subject to the approval of THE PIHP.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant, employer and/or managing employer are informed of the participant-directed (individual and family directed) budget amount by the care coordinator. A budget adjustment may be requested at any time by directing the care coordinator to prepare a ISP revision that includes the reason for the need for the adjustment. The care coordinator has a standard form that is used in requesting budget adjustments that is attached to the plan revision.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

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<input type="checkbox"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="checkbox"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget, or to address potential service delivery problems that may be associated with budget underutilization, and the entity (or entities) responsible for implementing these safeguards:

The financial supports agency and agency with choice track the individual and family directed supports budget per a standard reporting format developed with and approved by THE PIHP. The report is completed monthly by the Financial Supports Agency and Quarterly by the Agency with Choice and is provided to the employer or Agency with Choice, THE PIHP and care coordinator. "Red Flags" that are indicators of potential problems in revenues (under utilization) or spending (over utilization) are identified. The Financial Supports Agency, or any other entity that receives the report, are alert to these red flags so that the care coordinator and/or PIHP may address the issue immediately with the employer or managing employer. The employer or managing employer may be required to develop a corrective action plan. Continued under or over utilization of the budget may result in removal from individual and family directed supports and a return to agency directed supports.

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Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing: Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The NC Innovations waiver operates concurrently with a 1915(b) waiver through a PIHP. All waiver applicants/participants are notified of their right to request a fair hearing by THE PIHP in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Participants are required to access their PIHP's internal appeal process before requesting a hearing with the State.

Upon enrollment in THE PIHP, THE PIHP sends each enrollee a brochure explaining Medicaid appeal rights. For participants with limited literacy, the care coordinator verbally explains their appeal rights. When applicants/participants are denied participation in the waiver or specific waiver services are denied, terminated, suspended or reduced, THE PIHP sends a written notice to the individual explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the state level hearing processes and toll free numbers for the Medicaid agency and for requesting free legal assistance. Notices of termination, suspension or reduction are mailed to the participant a minimum of 10 days before the service is actually reduced, terminated or suspended.

As stated above, applicants/participants must avail themselves of the appeal process offered by THE PIHP before accessing the state fair hearing process. This requirement can be found in the concurrent 1915(b) waiver (#NC 02.RO1), subsection 3a of section E, "Grievance System". If the applicant/participant requests a hearing, THE PIHP gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. THE PIHP sends a written notice of the reconsideration decision to the individual, along with detailed instructions on requesting a hearing with the State. Applicants/participants may then request an informal appeal with the North Carolina DHHS and/or a formal appeal with the North Carolina Office of Administrative Hearings (OAH).

If the individual requests an informal hearing with DHHS, the DHHS hearings office sends a written notice of the decision, including instructions on how to access a formal hearing with the OAH and notification of the right to further appeal to Superior Court.

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When the suspension, reduction or termination of service is appealed, participants may continue to receive services up through the final decision by the OAH as long as they meet the appeal deadlines, the original period covered by the authorization has not expired and the participant requests continuation of the service.

Copies of all notices and documentation of decisions are maintained by the agency from which they originate. THE PIHP maintains records on the local reconsideration, the DHHS Hearings Office maintains records on the informal hearing and the OAH maintains records on the formal hearing.

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Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input checked="" type="checkbox"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input type="checkbox"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process and (c) how the right to a Medicaid fair hearing is preserved when a participant elects to make use of the process: state laws, regulations and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

THE PIHP has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an “action” and a grievance process for addressing grievances (complaints). “Actions” include the denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service, denial of payment for a service, failure to provide services in a timely manner as specified in the risk contract and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

A grievance (complaint) is an enrollee’s expression of dissatisfaction with any aspect of their care other than the appeal of an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee’s rights

The requirements for THE PIHP’s internal appeal and grievance processes are outlined in Section 6 and Attachment P of THE PIHP contract. The requirements cover the types of information that THE PIHP must provide to enrollees about grievances and appeals, provision of assistance to enrollees in completing necessary forms, reporting and record keeping, content of notices, expedited authorization decisions, continuation of benefits during appeals and timeframes for addressing grievances and appeals.

THE PIHP provides quarterly reports to the State Medicaid Agency on the types, number and resolution status of grievances and appeals. Tracking and analysis of grievances and appeals are to be used for internal quality improvement.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input checked="" type="checkbox"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>).

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DMH/DD/SAS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMH/DD/SAS Rule 10A NCAC 27G.0609 requires THE PIHP to report to DMH/DD/SAS all complaints (grievances under 42 CFR 438 Subpart F) made to THE PIHP not less than quarterly. The submission of THE PIHP complaint report is included in the contract between THE PIHP and DHHS. Four documents provide procedures and instructions relative to the complaint process:

- 1. Guidelines for THE PIHP complaint reporting system**
- 2. Customer service collection forms**
- 3. PIHP quarterly complaint report**
- 4. Complaint reporting instructions**

A copy of THE PIHP’s quarterly complaint report is shared with THE PIHP Client Rights Committee and THE PIHP Consumer and Family Advisory Committee in order to develop strategies for system improvement.

Guidelines require the documentation of any concern, complaint, compliment, investigation and request for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities and/or substance abuse services, local management entity or MH/DD/SAS service provider.

Complaint Reporting Categories include:

- (1) Abuse, neglect and exploitation**
- (2) Access to services**
- (3) Administrative issues**
- (4) Authorization/payment/billing**
- (5) Basic needs**
- (6) Client rights**
- (7) Confidentiality/HIPAA**
- (8) PIHP services**
- (9) Medication**
- (10) Provider choice**

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- (11) Quality of care**
- (12) Service coordination between providers**
- (13) Other to include any complaint that does not fit the previous areas.**

Information is recorded on the customer service form and recorded in THE PIHP complaint database for analysis. Action taken by THE PIHP is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of complaints that may be made. The total number of calendar and working days from receipt to completion are also recorded.

If the complainant is not satisfied with the initial resolution, he or she may request to appeal the decision.

The quarterly complaint reporting form includes the aggregate information on complaints to include:

- (1) The total number of complaints received by the customer service office**
- (2) The total number of persons (by category) who are reporting complaints**
- (3) The total number of consumers by age group**
- (4) The total number of consumers by disability group (if applicable) involved in the complaint**
- (5) The primary nature of the complaints/concerns (by category)**
- (6) A summary of data analyses to identify patterns, strategies developed to address problems and actions taken**
- (7) An evaluation of results of actions taken and recommendations for next steps.**

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As stated in Appendix F-2 above, grievances (complaints) are also reported to the state Medicaid agency on a quarterly basis as required by the risk contract with THE PIHP. The state Medicaid agency and the DMH/DD/SAS have developed a reporting form to increase consistency of processes to the extent possible.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

<input checked="" type="checkbox"/>	Yes. The State operates a critical event or incident reporting and management process <i>(complete Items b through e)</i>
<input type="checkbox"/>	No. This Appendix does not apply <i>(do not complete Items b through e)</i> . <i>If the State does not operate a critical event or incident reporting and management process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.</i>

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHHS Incident and Death Response System Guidelines describes who must report the documentation required, what/when/where reports must be filed and the levels of incidents, including responses to each level of incidents. Applicable laws and rules include: North Carolina Statute G.S. 122C and Client Rights Rules, APSM 95-2.

Critical incidents are defined as any happenings which are not consistent with routine operation of a facility, or service, in the routine care of consumers and that is likely to lead to adverse effects upon the consumer. Any incidents containing allegations or substantiations of abuse, neglect or exploitation must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect or exploitation allegations. Other reports may be required by law, such as reports to law enforcement. Facts regarding the incident should be reported objectively, in writing, without unsubstantiated conclusions, opinions or accusations. Incident reports are maintained in administrative files; however, incidents that have an effect on the participant must be recorded in the progress note of the participant record, as would any other consumer care information. Incident reports, including follow-up action requirements, are defined as one of three levels.

Level I Incidents are reported to THE PIHP on THE PIHP Incident Reporting form, or a form developed by the provider agency that contains required state elements. Level I incidents are defined as any incident that does not meet the requirements to be classified as a Level II or Level III incident. Examples of Level I incidents include, but are not limited to: consumer injury that does not require treatment by a licensed health care professional, employee and visitor injuries, property damage to include all accidents in vehicles and

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HIPAA/confidentiality violations. Level I incident reports are reviewed by the employee's supervisor, managing employer or employer of record and are submitted to a designated person, per agency policy, or maintained in the administrative files of the employer of record. THE PIHP also requires that Level 1 incidents for NC Innovations participants include reporting of failure to provide backup staffing. A quarterly report summarizing Level I incidents is submitted to THE PIHP, who in turns submits a quarterly report to DMH/DD/SAS, an agency within DHHS.

Level II Incidents include any incident that involves a threat to a consumer's health or safety or a threat to the health and safety of others due to consumer behavior. Level II incidents are reported immediately to the employee's supervisor, employer of record, or managing employer. The managing employer immediately notifies the agency with choice. A written report is prepared that is submitted to and reviewed by the employee's supervisor, employer of record, or managing employer. The managing employer forwards the report to the agency with choice. The written report is forwarded to THE PIHP within 72 hours of the incident's occurrence.

Level III Incidents include any incident that results in a death or permanent physical or psychological impairment to a consumer, a death or permanent physical or psychological impairment caused by a consumer or a threat to public safety caused by a consumer. Level III incidents are reported immediately to the employee's supervisor, employer of record or managing employer. The managing employer immediately notifies the agency with choice. The supervisor (including the financial support service provider in the Agency with Choice model) or Employer of Record immediately notifies THE PIHP, who notifies DMH/DD/SAS. THE PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared that is submitted to and reviewed by the employee's supervisor (including the Agency with Choice) or Employer of Record. The written report is forwarded to THE PIHP within 72 hours of the incident's occurrence. All providers (including the Agency with Choice) and Employers of Record are required to conduct a peer review of Level III incidents, beginning within 24 hours of the incident.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of entry into THE PIHP, participants are provided a consumer and family member handbook that outlines their rights, protections and the advocacy agencies who can educate and assist in the event of a concern. The care coordinator discusses the rights and protections, inclusive of agencies, to contact with the participant/legally responsible person as a component of the admissions process to the NC Innovations waiver. Opportunities for information training occur during routine monitoring.

Providers within THE PIHP network are required to inform the participant of rights and protections through individual agency procedure. When a participant elects the individual/family directed supports option, employers, managing employers, representatives and/or managing employers receive the employer handbook that details their rights, protections and agencies available to assist them in a self-directed services model.

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THE PIHP and the NC DHHS operate toll-free care lines where participants can receive additional information or assistance, if needed. These lines have the capacity to assist participants that are primarily Spanish speaking and/or hearing impaired.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident reporting requirements and responses are based on state laws and regulations for each of the three levels of incidents.

Level 1 Incidents are maintained by the provider agency (including the agency with choice) and employer of record. Each provider agency (including the Agency with Choice) or Employer of Record is required to submit a quarterly report of Level I incidents to THE PIHP. Aggregate information on Level I incidents, medication errors and searches/seizures includes:

- (1) Total number of incidents**
- (2) Total number of consumers who were involved**
- (3) Average number of incidents per consumer**
- (4) Highest number of incidents for any one consumer**
- (5) Patterns and/or trends found in internal quality improvement process**
- (6) How problems found are being addressed**

THE PIHP also requires that Level 1 incidents for NC Innovations participants include reporting of failure to provide backup staffing.

THE PIHP submits a Level I incident report to DMH/DD/SAS, an agency within DHHS, quarterly. In addition, THE PIHP reviews a sample of documented responses as part of local monitoring. THE PIHP also analyzes trends and patterns in Level I medication errors, searches and seizures and restrictive interventions as part of quality improvement and monitoring planning processes.

Written reports of Level II incidents are forwarded to THE PIHP within 72 hours of the incident's occurrence. The provider agency (including the Agency with Choice) and Employer of Record are responsible for attending to the health and safety of involved parties as well as analyzing causes, correcting problems and review in quality improvement process to prevent similar incidents. Level II incidents may signal a need for THE PIHP to review the provider's clinical care and practices and THE PIHP's management processes, including service coordination, service oversight and technical assistance for providers. These incidents require communication between the provider and THE PIHP, documentation of the incident and report to THE PIHP and other authorities as required by law. THE PIHP is responsible for reviewing provider handling of the incident and ensuring consumer safety.

Level III Incidents are immediately reported to THE PIHP who notifies DMH/DD/SAS. THE PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared and reviewed by the agency or employer submitting the incident. The written report is forwarded

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to THE PIHP within 72 hours of the incident's occurrence. Providers (including the Agency with Choice) and Employers of Record attend to the health and safety needs of involved parties, and conduct a peer review of Level III incidents beginning within 24 hours of the incident. The internal review:

- (1) Ensures the safety of all concerned
- (2) Takes action to prevent a reoccurrence of the incident
- (3) Creates and secures a certified copy of the consumer record
- (4) Ensures that necessary authorities and persons are notified within allowed timeframes
- (5) Conducts a root cause analysis once all needed information is received.

Level III incidents signal a need for DHHS, including the Division of DMH/DD/SAS and THE PIHP, to review the local and state service provision and management system, including coordination, technical assistance and oversight. These incidents require communication among the provider, THE PIHP and DHHS, documentation of the incident, and report to THE PIHP, DHHS and other authorities as required by law. THE PIHP reviews provider handling of the Level III incident:

- (1) To ensure that consumers are safe
- (2) A certified copy of the participant record is secured
- (3) A review committee meeting is convened
- (4) Appropriate agencies are informed

DMH/DD/SAS reviews THE PIHP oversight of providers and follows up, as warranted, to ensure problems are corrected.

THE PIHP also analyzes and responds to patterns of incidents as part of quality improvement and monitoring processes. THE PIHP reports aggregate information, trends and actions taken to DMH/DD/SAS quarterly. DMH/DD/SAS analyzes and responds to statewide patterns of incidents as part of quality improvement and monitoring. DMH/DD/SAS also produces statewide incident trend reports quarterly.

Other agency responsibilities for follow-up of incidents are:

- (1) Local law enforcement agencies investigate legal infractions and take appropriate actions
- (2) Local Department of Social Services investigates abuse, neglect or exploitation allegations and takes appropriate actions
- (3) The Health Service Regulation Division of DHHS investigates licensure infractions and take appropriate actions
- (4) The Health Care Personnel Registry section of the Health Services Regulation Division investigates personnel infractions and takes appropriate actions
- (5) The Governor's Advocacy Council for Persons with Disabilities analyzes trends and advocates as warranted

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A summary of incident reporting and follow-up actions is included in THE PIHP'S reporting to DMA.

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- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DHHS Division of MH/DD/SAS provides oversight and response to critical incidents. The oversight and frequency depends on the level of incident. State responses to critical incidences are described in item d above and in the DHHS incident and death response system guidelines.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion (select one):

<input type="checkbox"/>	The State does not permit or prohibits the use of restraints or seclusion. Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
<input checked="" type="checkbox"/>	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMH/DD/SAS Rule 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.

Facilities, including provider agencies and agencies with choice, must implement policies and procedures that emphasize the use of alternatives to restrictive interventions. Prior to providing services to participants, staff must demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities, or others or property damage, is prevented. Agencies must establish training based on state competencies, monitor for internal compliance and demonstrate that they acted on the data gathered. Formal refresher training must occur at least annually. The specific competencies, instructor qualifications and other training requirements are included in the rule.

Employers of record are required to provide or arrange for employee training on alternatives to restrictive interventions.

DMH/DD/SAS Rule 10A NCAC 27E.0108 addresses Training in Seclusion, Physical Restraint and Isolation Time Out.

Seclusion, physical restraint and isolation time out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Staff authorized to employ and terminate these procedures are retrained and demonstrate competency at least annually. This training must occur prior to the provision of direct service to any participant whose ISP includes restrictive interventions. Instructor qualifications and training course content regulations are included in the rule.

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Restrictive interventions are reported via the incident reporting regulations. The DHHS Restrictive Intervention Details Report is completed along with the incident report.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

State agencies and THE PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. State agencies require THE PIHP to report quarterly data from the incident reports given to THE PIHP. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and THE PIHP.

b. Use of Restrictive Interventions

<input type="checkbox"/>	The State does not permit or prohibits the use of restrictive interventions. Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
<input checked="" type="checkbox"/>	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

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- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The state requires provider agencies to maintain intervention advisory or client rights committees to provide oversight and periodic reviews of all restraints, restrictive interventions and rights restrictions. Provider agencies are required to analyze data at an aggregate and consumer level to provide to the intervention advisory or client rights committees. The provider agencies' intervention advisory or client rights committee reviews the information for patterns and trends as well as give approval on behavior modification measures implemented on a planned or unplanned basis. These reports must be made available to THE PIHP or state agencies as requested.

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Reports are generated to state agencies quarterly by THE PIHP. Provider agencies are required to report to THE PIHP quarterly.

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

<input checked="" type="checkbox"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Provider agencies, including agencies with choice, are required to have a pharmacist or physician complete quarterly medication/drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by THE PIHP with the provider agency. Employers of record are required to train or arrange for training of their employees in medication administration if applicable.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

State rules and regulations outline requirements for policies and procedural precautions which must be implemented for medication management, which includes prohibited practices. Provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by the state regulatory entities during annual or complaint reviews.

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

<input checked="" type="checkbox"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (<i>complete the remaining items</i>)
<input type="checkbox"/>	Not applicable (<i>do not complete the remaining items</i>)

- ii. State Policy.** Summarize the policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State rules and regulations outline requirements for policies and procedures to be implemented for medication administration, including self-medication. Consumers

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who self-medicate are required to have an assessment on their ability to self-medicate and a physician must sign an order for self-medication. Documentation must be maintained as outlined in state rules/regulations.

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iii. Medication Error Reporting. *Select one of the following:*

<input checked="" type="checkbox"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a state agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify state agency (or agencies) to which errors are reported:
	Provider agencies, agencies with choice and employers of record report medication errors to THE PIHP who, in turn, reports the errors to the Division of MH/DD/SAS through incident reporting described in Appendix G-1.
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	Errors reported include: wrong or missed dosage, wrong medication, wrong time (over 1 hour from prescribed time) or medication refusals by the participant
	(c) Specify the types of medication errors that providers <i>must</i> report to the State:
	Any error that results in permanent physical or psychological impairment is reported to the Division of MH/DD/SAS via Level III incident reporting. Any error that does not threaten the individual's health and safety, as determined by a physician or pharmacist notified of the error is reported via Level I incident reporting.
<input type="checkbox"/>	Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

THE PIHP reports medication errors via incident reporting described in Appendix G-1. This includes Quarterly Reporting to the Division of DMH/DD/SAS.
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Quality Management: Health and Welfare

As a distinct component of the State’s quality management strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.

a.i. *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

Performance Measure:	<i>Proportion of waiver participants whose health and welfare is monitored according to the waiver process and care coordinator using the State approved health and safety monitoring tool</i>		
Data Source Record Reviews	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):

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	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Proportion of waiver participants for whom health and welfare issues are discovered and substantiated to ensure that appropriate remediation took place</i>		
Data Source Incident Reporting Record Review Mortality Reviews Analyze Collected Data	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

Performance Measure:	<i>Proportion of waiver participants who are in need of a crisis plan and for whom a crisis plan has been developed.</i>		
Data Source Incident Reporting Record Review	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):

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Mortality Reviews Analyze Collected Data	<i>that applies):</i>	<i>applies):</i>	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	THE PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
	THE PIHP	<input type="checkbox"/> Other (Specify):	

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

N/A

b. Methods for Remediation

b.i Describe the State’s strategy for addressing individual problems as they are discovered.

THE PIHP will analyze and address problems identified and include the analysis in the report to DMA and the intra-departmental monitoring team. DMA will require corrective action plans as needed. THE PIHP develop corrective action plans that are submitted and approved by DMA. As corrective action is completed, THE PIHP report to DMA who monitors the action until the corrective action is completed.

DMA requires THE PIHP to contact DMA immediately about any issue that has or may have a significant negative impact on participant health and welfare. DMA and THE PIHP work

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together to resolve such issues as they occur.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

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- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;

The *remediation* processes followed when problems are identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes the *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;

- The correspondent *roles/responsibilities* of those conducting assessing and improving system functions around the assurances; and

- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy. In instances when the QMS spans more than one waiver, the State must be able to provide waiver-specific information.

H.1 Systems Improvement

H.1.a.i Describe the process for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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The NC Innovations waiver operates under the umbrella of a 1915(b) waiver, and both State Plan MH/DD/SA services and NC Innovations services are delivered through PIHPs under the terms of risk contracts. 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. PIHPs report on performance measures and performance improvement projects and an External Quality Review (EQR) contract was 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 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 now in place, the goal during the upcoming renewal period 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.

As stated above, performance measure reporting related mainly to state plan MH/DD/SA services through THE PIHP have already been implemented. The 1915(c) waiver application contains 26 performance measures specific to the NC Innovations 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.

Quarterly quality management meetings with the DMA, the DMH/DD/SAS and THE PIHP have been in place since implementation of the waiver program and will be instrumental during the phase-in and operation of new PIHPs. The meetings have focused a great deal on implementation of the overall concurrent waiver program and activities specific to Medicaid managed care, including reporting requirements, refining of reports and implementation of EQR activities. This setting provides an excellent backdrop for operationalizing the NC Innovations performance measures and moving to the next level of trending, analyzing and setting benchmarks for all services delivered through THE PIHP.

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An Intradepartmental Monitoring Team (IMT) which meets with THE PIHP quarterly, and conducts annual on-site reviews of PIHPs' operations, has been active since the waivers were implemented and will be employed for the phase-in PIHPs. Up until now, the IMT has focused heavily on the transition of the THE PIHP local management entity into a fully functional managed care entity 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. As the State believes that THE PIHP have successfully made this transition, IMT activities will take on more of a quality improvement, rather than an implementation, focus in both clinical and non-clinical areas.

The State and THE PIHP have implemented corrective action plans based on specific monitoring activities (such as the annual on-site review) and they have been excellent vehicles for bringing about positive system changes. Appendix A of the application describes several discovery activities that the State Medicaid Agency will conduct in exercising its administrative authority over the waiver. All of these 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, the 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.

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H.1.a.ii

System Improvement Activities	Responsible Party (check each that applies)	Frequency of monitoring and analysis (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly (analysis)
	<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input checked="" type="checkbox"/> Other: Specify (monitoring) Ongoing

H.1.b.i. Describe the process for monitoring and analyzing the effectiveness of system design changes, including a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The effectiveness of system design changes – for example, a revised process to initiate the delivery of services more promptly – will be evident through ongoing monitoring activities using the same performance measures. Once performance measures are implemented and THE PIHP have an initial baseline year of service experience, the State and THE PIHP will jointly develop benchmark priorities. The DMA Behavioral Health and waiver teams and THE PIHP QM teams will work jointly through the quarterly quality management meetings to assess system changes and begin developing benchmarks. The IMT will serve in an advisory and oversight capacity.

H.1.b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy for the NC Innovations waiver is incorporated in the managed care quality strategy as required by 42 CFR 438.202. The quality strategy is reviewed by the quality staff of DMA through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the quality strategy is reviewed on an annual basis in the fourth quarter of each calendar year and revised based upon analysis of results by the quality management staff in DMA and the intradepartmental monitoring (IMT). The quality strategy may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed that is congruent with the overall quality strategy. The development process

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begins with an assessment of the accomplishments of the prior year's quality plan, the EQR technical report, and incorporates input from committees and other established quality forums that include governmental agencies, Providers, THE PIHP, consumers and advocates determining areas of focus for quality activities such as quality improvement measures, improvement projects and performance indicators.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS, upon request, through the Medicaid agency or the operating agency (if applicable).

The NC Innovations waiver operates concurrently with a 1915(b) waiver and all services are provided through a PIHP. In accordance with the risk contract between the state Medicaid agency and THE PIHP, the DMA makes a capitated payment monthly to THE PIHP for each enrollee and THE PIHP provides all needed MH/DD/SA services through their provider networks. Section 9.4 of the contract requires THE PIHP to implement a compliance plan to guard against fraud and abuse, to conduct provider audits to verify that services authorized and paid for by THE PIHP are actually provided and to take disciplinary action when needed. THE PIHP report any incidents of fraud and abuse to DMA. Provider agencies are monitored at a frequency set by THE PIHP but no less than every three years.

Section 6 of the contract also requires that THE PIHP' annual financial reports be audited in accordance with Generally Accepted Auditing Standards by an independent certified public accountant. THE PIHP provide copies of the annual audit to DMA. The annual financial audit is subject to independent verification and audit by a firm of DMA's choosing.

DMA assures that services are provided to waiver participants appropriately through several required activities described in the contract, such as routine financial and clinical reports by THE PIHP, administration of consumer and provider surveys by THE PIHP or an external entity, on-site reviews of operational processes and procedures, record reviews and external quality review activities through an independent entity.

The entity responsible for conducting the independent audit of the waiver required by the Single Audit Act is the North Carolina Office of the State Auditor.

Quality Management: Financial Accountability

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

A. Methods for Discovery:

Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants,

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authorized in the service plan and properly billed by qualified waiver providers in accordance with the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	<i>Proportion of claims that are billed to THE PIHP for NC Innovations waiver services that are provided as required by the terms of the waiver</i>		
Data Source: Provider record reviews by THE PIHP	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample with confidence interval of 95%
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other (Specify):	
			<input type="checkbox"/> Other: Describe:
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other (Specify):	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other (Specify):	
		Semi-annually	

Performance Measure:	<i>DMA reviews THE PIHP rate setting methodology for compliance with federal managed care regulations and the DMA-PIHP contract as specified below.</i>		
Data Source: PIHP provider rate-setting	Responsible party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling approach (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review

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	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
	PIHP	<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Upon development and when changes to methodology are made	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other: Specify</i>
	<input type="checkbox"/> <i>Other (Specify):</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Other (Specify):</i>	
		Upon development and when changes to methodology are made	

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

Medicaid capitated payments to THE PIHP are developed and certified by actuarial staff in accordance with managed care requirements for contracts and rate development in 42 CFR Part 438. The actuaries use PIHP encounter data to set the rates and take into consideration any program or policy changes that might impact the waiver program.

B. Methods for Remediation

1. Describe the State’s strategy for addressing individual problems as they are discovered.

THE PIHP has the authority to require corrective action plans of each of their providers and recoup payments when finding that services are provided inappropriately – i.e., services are not provided in accordance with program requirements. THE PIHP may require the providers to implement corrective action plans depending on the severity and nature of the problem. When significant problems are detected that may impact the health and safety of consumers, THE PIHP report to the State immediately. The State assists with remediation as appropriate and may require corrective actions by THE PIHP.

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2. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	Method of aggregation reporting (check each that applies):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other (Specify):	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other (Specify):	

3. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

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APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State employs an actuary to calculate an actuarially sound payment rate per 42 CFR 438.6(c).

THE PIHPs are responsible for setting all provider rates for waiver services. THE PIHP set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. THE PIHP use the State's Medicaid rates for similar services as a guide in setting rates.

All proposed changes to existing rates or for implementing new rates are reviewed internally by THE PIHP and externally by a PIHP provider advisory committee. The provider council is comprised of a cross section of THE PIHP' provider networks. Rate reviews focus on internal and external equity and consistency. Providers are notified of rate changes by announcement at the provider meetings and online posting on THE PIHP' website.

THE PIHP reimburse waiver service providers on a FFS basis for most services and for most providers. To the extent that providers are capitated, then service level encounter data is provided so that the State can track services and set PIHP capitated rates.

THE PIHP uses the same reimbursement rates for all providers for the same waiver services. For services provided through the individual family directed option (employer of record model), the administrative portion of the service rate is set aside to cover charges for other administrative costs. The direct service portion of the rate is made available to the employer of record for wages and benefits.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The NC Innovations waiver operates concurrently with a 1915(b) waiver, #NC-02.R01. Capitated payments for each waiver enrollee are made to THE PIHP monthly through the State's Medicaid Management Information System (MMIS), in accordance with Section A.I.B of the concurrent 1915(b) waiver, "Delivery Systems" and Section 10 of the risk contract between the state Medicaid agency and THE PIHP. The capitated payments are considered payment in full for all services covered under the 1915(b)/1915(c) concurrent waivers.

Individual providers bill THE PIHP according to the terms of the contract between THE PIHP and its providers. Section 11 of the risk contract between the state Medicaid agency and THE PIHP outline requirements for subcontracting and timeliness of payment to

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providers by THE PIHP. THE PIHP may not contract with a subcontractor who is not eligible for participation in the Medicaid program.

c. Certifying Public Expenditures (select one):

<input type="checkbox"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services, (b) how it is assured that the CPE is based on the total computable costs for waiver services and (c) how the State verifies that the CPEs are eligible for federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur CPEs for waiver services, (b) how it is assured that the CPE is based on total computable costs for waiver services, and (c) how the State verifies that the CPEs are eligible for federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="checkbox"/>	No. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service, (b) when the service was included in the participant’s approved service plan and (c) the services were provided:

At the State Level:
 The State determines eligibility for capitated payments by identifying individuals through the MMIS who, as of a set date at the end of each month, are eligible for Medicaid, reside in one of the counties covered by the waiver and have a special indicator that signifies participation in an HCBS waiver for individuals meeting the ICF-MR level of care. (The special indicator is entered in the State’s Eligibility Information System (EIS) by the local department of social services upon notification from THE PIHP that the individual has been approved for waiver participation. Eligibility changes are transmitted to the MMIS on a nightly basis.) The MMIS generates a capitated payment to THE PIHP at the beginning of the following month for each waiver participant identified through this process. DMA requires THE PIHP to review a representative sample of records and encounter data periodically to determine whether assurances as to service plans and service delivery are met and report findings to DMA.

At THE PIHP/Local Levels:
 Eligibility for waiver participation is determined by THE PIHP and eligibility for Medicaid is determined by the local DSS. Initial LOC determinations are made by THE PIHP. THE PIHP

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notifies the DSS when eligibility for waiver participation is authorized, the DSS then enters the special waiver indicator into the EIS and the indicator is transmitted to the MMIS. The MMIS generates an enrollment report at the end of each month, which identifies waiver participants for whom payment will be made at the beginning of the next month. THE PIHP use this report to verify that waiver eligibility has been entered into the system and to identify any waiver participants who have lost Medicaid eligibility. Regarding payment for waiver services according to the plan of care, authorization for the individual waiver services in the plan is entered into THE PIHP' claims payment system, which prevents payment for unauthorized services. THE PIHP monitor service delivery through care coordinator contact with waiver participants and billing audits of providers.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable) and providers of waiver services for a minimum period of three years, as required in 45 CFR §74.53.

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APPENDIX I-3: Payment

a. Method of payments – MMIS (*select one*):

<input type="checkbox"/>	Payments for all waiver services are made through an approved MMIS.
<input type="checkbox"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS and (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="checkbox"/>	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS and (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
<input checked="" type="checkbox"/>	<p>Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:</p> <p>Eligibility for waiver participation is entered into the State's EIS by the local departments of social services in the participating counties once the determination has been made that the individual is Medicaid eligible and THE PIHP have notified the social services agency that the individual has been authorized to participate in the waiver. The EIS transmits eligibility to the MMIS, which pays a capitated payment to THE PIHP monthly for each waiver participant. Capitated payments continue until one of the following occurs: the individual loses Medicaid eligibility, the individual moves to a county outside of the managed care catchment areas or the social services agency, upon instruction from THE PIHP, removes the individual from the waiver. For waiver participants who have deductibles (spend-downs), the MMIS pays prorated capitated payments based on the date the deductible is met.</p>

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

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<input checked="" type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.
	Not applicable

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="checkbox"/>	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

<input type="checkbox"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i>
<input checked="" type="checkbox"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

e. Amount of Payment to Public Providers. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and if so, how the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="checkbox"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="checkbox"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

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<input type="checkbox"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input type="checkbox"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="checkbox"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims or payment processes that result in less than 100 percent reimbursement of providers. Include: (a) the methodology for reduced or returned payments, (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned and (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input checked="" type="checkbox"/>	Providers are paid by a managed care entity (or entities) that are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.
<p>THE PIHP retain 100 percent of the monthly capitated payment as of this date. During the initial year of waiver operation, the State generated waiver savings – i.e., the cost of providing both state Plan and waiver services was less than the waiver projection. The 1915(b) waiver was amended and approved by CMS to reinvest all state savings into 1915(b)(3) services.</p>	

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="checkbox"/>	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
<input checked="" type="checkbox"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

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ii. Organized Health Care Delivery System. Select one:

<input type="checkbox"/>	<p>Yes. The waiver provides for the use of organized health care delivery system (OHCDS) arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements and (f) how financial accountability is assured when an OHCDS arrangement is used:</p>
<input checked="" type="checkbox"/>	<p>No. The State does not employ OHCDS arrangements under the provisions of 42 CFR §447.10.</p>

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

<input type="checkbox"/>	<p>The State contracts with MCOs and/or PIHPs or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans and (d) how payments are made to the health plans.</p>
<input checked="" type="checkbox"/>	<p>This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or PIHP or a PAHP. The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.</p>
<input type="checkbox"/>	<p>The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.</p>

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APPENDIX I-4: Non-Federal Matching Funds

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input type="checkbox"/>	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
<input type="checkbox"/>	Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or fiscal agent, such as an IGT, including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

<input checked="" type="checkbox"/>	Appropriation of Local Revenues. Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or fiscal agent, such as an IGT, including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
Local revenues are allocated through a county's general fund. Those funds are derived from a variety of sources, most of them being taxes. Funds are transferred electronically from all 100 counties each month.	
<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the entity or agency receiving funds and (c) the mechanism that is used to transfer the funds to the state Medicaid Agency or fiscal agent, such as an IGT, including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
<input type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

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c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations and/or (c) federal funds (other than FFP). *Select one:*

<input type="checkbox"/>	None of the specified sources of funds contributes to the non-federal share of computable waiver costs.
<input type="checkbox"/>	The following source (s) is used. <i>Check each that applies.</i>
<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
For each source of funds indicated above, describe the source of the funds in detail:	

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input type="checkbox"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="checkbox"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The capitated payments to THE PIHP were initially based on expenditures for similar services in the FFS MR/DD waiver that serves the rest of the State. FFS payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources are used by the State and local governments to pay for room and board in licensed residential facilities.

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="checkbox"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i></p> <div style="background-color: #cccccc; height: 50px; width: 100%;"></div>
<input checked="" type="checkbox"/>	<p>No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="checkbox"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="checkbox"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants, as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="checkbox"/>	No. The State does not impose a premium, enrollment fee or similar cost-sharing arrangement on waiver participants.
<input type="checkbox"/>	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost sharing and the groups who are excluded and (d) the mechanisms for the collection of cost sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Updated Appendix J-1

Level(s) of Care (<i>specify</i>):			ICF-MR				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 4 - Column 7)
1	\$41,620	\$11,981	\$53,601	\$106,108	\$5,546	\$111,654	\$58,057
2	\$43,434	\$13,035	\$56,469	\$109,292	\$6,093	\$115,385	\$58,913
3	\$45,860	\$14,235	\$60,095	\$112,570	\$6,702	\$119,272	\$59,177
4	\$48,391	\$15,562	\$63,953	\$115,948	\$7,381	\$123,329	\$59,375
5	\$50,521	\$17,032	\$67,553	\$119,426	\$8,139	\$127,565	\$60,013

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	625		
Year 2	635		
Year 3	670		
Year 4 (renewal only)	2081		
Year 5 (renewal only)	4461		

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay for the waiver is 324 days. This figure is actual average length of stay for waiver participants from April 2006 through March 2007.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

CMS 372 reports serve as the base data. The data has been projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). The MCO has also provided utilization estimates by service during the renewal period, which were considered alongside the rate setting trends. There are also a few new services for which utilization estimates were the basis for the cost projections. In some cases, such as financial supports and community guide, the State expects there will be increasingly higher utilization as more waiver recipients choose to self-direct their services. Thus, the percentage of people utilizing these services is expected to increase over the five-year renewal period.

In this waiver amendment, the financial calculations for Factor D have been updated to reflect the new services outlined in Appendix C-3 as well as the service limits. The cost estimates for Year 3 reflect the transition of the new services into the waiver based on each individual’s birth date. Years 4 and 5 reflect annual utilization estimates based on the new

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service package. In aggregate, the State does not anticipate significant changes to the cost of serving the waiver population, but costs have been realigned into the revised service array in Appendix C. These changes are incorporated for years 3, 4 and 5 of the waiver effective April 1, 2010.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available to identify other behavioral health costs for waiver participants. This data represented services rendered from April 1, 2005, through March 31, 2006, and was projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). This data includes the cost of short-term institutionalizations for individuals that returned to the waiver program.

The State also utilized FFS data to summarize the historical physical health costs for the waiver participants. This data represented services rendered from April 1, 2005, through March 31, 2006, and was also projected to each renewal year.

Pharmacy costs were adjusted to account for reduced Medicaid expenditures as a result of Medicare Part D, effective January 1, 2006. Pharmacy costs were estimated based on expenses incurred by waiver recipients after January 1, 2006.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available for ICF-MR costs for individuals in the Piedmont area. This data represented services rendered from April 1, 2005 through March 31, 2006 and was projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). This data includes individuals that may have entered the facility while they were a waiver recipient, but never returned to the waiver.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available to identify other behavioral health costs for institutionalized individuals. This data represented services rendered from April 1, 2005, through March 31, 2006, and was projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007).

The State also utilized FFS data to summarize the historical physical health costs for individuals residing in ICF-MR facilities. This data represented services rendered from April 1, 2005, through March 31, 2006, and was also projected to each renewal year.

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Pharmacy costs were adjusted to account for reduced Medicaid expenditures as a result of Medicare Part D, effective January 1, 2006. Pharmacy costs were estimated based on expenses incurred by ICF-MR recipients after January 1, 2006.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

- The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
- The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

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Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care	<input checked="" type="checkbox"/>	15-minute	-	5,594	\$3.66	\$0
Residential Supports	<input checked="" type="checkbox"/>	Day	182	360	\$122.52	\$8,027,510
Day Supports	<input checked="" type="checkbox"/>	15-minute	221	3,599	\$4.71	\$3,746,235
Supported Employment	<input checked="" type="checkbox"/>	15-minute	67	1,537	\$8.60	\$885,619
Respite	<input checked="" type="checkbox"/>	15-minute	338	1,130	\$4.12	\$1,573,593
Assistive Technology: Equipment and Supplies (incl PERS)	<input checked="" type="checkbox"/>	event	49	9	\$254.35	\$112,168
Assistive Technology: Communication Devices	<input checked="" type="checkbox"/>	event	12	1	\$2,359.70	\$28,316
Community Guide	<input checked="" type="checkbox"/>	15-minute	55	207	\$9.64	\$109,751
Community Networking	<input checked="" type="checkbox"/>	15-minute	33	1,305	\$16.17	\$696,361
Community Transition	<input checked="" type="checkbox"/>	event	11	1	\$3,214.84	\$35,363
Crisis Services	<input checked="" type="checkbox"/>	15-minute	8	705	\$6.41	\$36,152
Assistive Technology: Home Modifications	<input checked="" type="checkbox"/>	event	1	1	\$1,538.31	\$1,538
In Home Intensive Supports	<input checked="" type="checkbox"/>	15-minute	-	-	\$0.00	\$0
Home Supports	<input checked="" type="checkbox"/>	15-minute	396	5,178	\$5.16	\$10,580,518
In Home Skill Building	<input checked="" type="checkbox"/>	15-minute	-	-	\$0.00	\$0
Individual Goods and Services	<input checked="" type="checkbox"/>	event	55	4	\$224.64	\$49,421
Natural Supports Education	<input checked="" type="checkbox"/>	15-minute	6	426	\$9.45	\$24,154
Specialized Consultation Services	<input checked="" type="checkbox"/>	15-minute	16	15	\$19.89	\$4,774
Assistive Technology: Vehicles	<input checked="" type="checkbox"/>	event	3	1	\$6,114.67	\$18,344
Financial Supports	<input checked="" type="checkbox"/>	event	55	14	\$107.16	\$82,513
GRAND TOTAL:						\$26,012,333
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						625
FACTOR D (Divide grand total by number of participants)						\$41,620
AVERAGE LENGTH OF STAY ON THE WAIVER						324

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Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care	<input checked="" type="checkbox"/>	15-minute	-	5,703	\$3.77	\$0
Residential Supports	<input checked="" type="checkbox"/>	Day	185	367	\$126.20	\$8,568,349
Day Supports	<input checked="" type="checkbox"/>	15-minute	220	3,669	\$4.71	\$3,801,818
Supported Employment	<input checked="" type="checkbox"/>	15-minute	68	1,567	\$8.85	\$943,021
Respite	<input checked="" type="checkbox"/>	15-minute	343	1,152	\$4.24	\$1,675,377
Assistive Technology: Equipment and Supplies (incl PERS)	<input checked="" type="checkbox"/>	event	50	9	\$261.98	\$117,891
Assistive Technology: Communication Devices	<input checked="" type="checkbox"/>	event	12	1	\$2,430.49	\$29,166
Community Guide	<input checked="" type="checkbox"/>	15-minute	112	211	\$9.93	\$234,666
Community Networking	<input checked="" type="checkbox"/>	15-minute	36	1,330	\$16.65	\$797,202
Community Transition	<input checked="" type="checkbox"/>	event	22	1	\$3,311.28	\$72,848
Crisis Services	<input checked="" type="checkbox"/>	15-minute	8	719	\$6.60	\$37,963
Assistive Technology: Home Modifications	<input checked="" type="checkbox"/>	event	1	1	\$1,584.45	\$1,584
In Home Intensive Supports	<input checked="" type="checkbox"/>	15-minute	-	-	\$0.00	\$0
Home Supports	<input checked="" type="checkbox"/>	15-minute	402	5,278	\$5.16	\$10,948,261
In Home Skill Building	<input checked="" type="checkbox"/>	15-minute	-	-	\$0.00	\$0
Individual Goods and Services	<input checked="" type="checkbox"/>	event	112	5	\$231.38	\$129,573
Natural Supports Education	<input checked="" type="checkbox"/>	15-minute	6	435	\$9.73	\$25,395
Specialized Consultation Services	<input checked="" type="checkbox"/>	15-minute	16	16	\$20.49	\$5,245
Assistive Technology: Vehicles	<input checked="" type="checkbox"/>	event	3	1	\$6,298.11	\$18,894
Financial Supports	<input checked="" type="checkbox"/>	event	112	14	\$110.38	\$173,076
GRAND TOTAL:						\$27,580,329
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						635
FACTOR D (Divide grand total by number of participants)						\$43,434
AVERAGE LENGTH OF STAY ON THE WAIVER						324

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Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Total Cost
Personal Care	<input checked="" type="checkbox"/>	15-minute	36	2,598	\$3.75	\$350,730
Residential Supports	<input checked="" type="checkbox"/>	Day	196	374	\$129.98	\$9,528,054
Day Supports	<input checked="" type="checkbox"/>	15-minute	228	3,714	\$4.71	\$3,988,390
Supported Employment	<input checked="" type="checkbox"/>	15-minute	72	1,586	\$9.12	\$1,041,431
Respite	<input checked="" type="checkbox"/>	15-minute	362	1,163	\$4.37	\$1,839,796
Assistive Technology: Equipment and Supplies (incl PERS)	<input checked="" type="checkbox"/>	event	52	9	\$269.84	\$126,285
Assistive Technology: Communication Devices	<input checked="" type="checkbox"/>	event	-	-	\$0.00	\$0
Community Guide	<input checked="" type="checkbox"/>	15-minute	178	216	\$10.23	\$393,323
Community Networking	<input checked="" type="checkbox"/>	15-minute	38	1,342	\$17.15	\$874,581
Community Transition	<input checked="" type="checkbox"/>	event	36	2	\$3,410.62	\$245,565
Crisis Services	<input checked="" type="checkbox"/>	15-minute	8	733	\$6.80	\$39,875
Assistive Technology: Home Modifications	<input checked="" type="checkbox"/>	event	1	1	\$1,631.99	\$1,632
In Home Intensive Supports	<input checked="" type="checkbox"/>	15-minute	13	2,598	\$4.74	\$160,089
Home Supports	<input checked="" type="checkbox"/>	15-minute	424	2,672	\$5.16	\$5,845,908
In Home Skill Building	<input checked="" type="checkbox"/>	15-minute	389	2,672	\$5.50	\$5,716,744
Individual Goods and Services	<input checked="" type="checkbox"/>	event	178	5	\$238.32	\$212,105
Natural Supports Education	<input checked="" type="checkbox"/>	15-minute	6	443	\$10.02	\$26,633
Specialized Consultation Services	<input checked="" type="checkbox"/>	15-minute	17	16	\$21.10	\$5,739
Assistive Technology: Vehicles	<input checked="" type="checkbox"/>	event	4	1	\$6,487.06	\$25,948
Financial Supports	<input checked="" type="checkbox"/>	event	178	15	\$113.69	\$303,552
GRAND TOTAL:						\$30,726,382
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						670
FACTOR D (Divide grand total by number of participants)						\$45,860
AVERAGE LENGTH OF STAY ON THE WAIVER						324

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Waiver Year: Year 4

Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care	<input checked="" type="checkbox"/>	588,360	111	5,296	\$3.75	\$2,204,460
Residential Supports	<input checked="" type="checkbox"/>	231,697	607	382	\$133.88	\$31,043,291
Day Supports	<input checked="" type="checkbox"/>	2,621,562	692	3,786	\$4.71	\$12,339,786
Supported Employment	<input checked="" type="checkbox"/>	359,252	222	1,617	\$9.39	\$3,370,766
Respite	<input checked="" type="checkbox"/>	1,334,132	1,126	1,185	\$4.50	\$6,004,395
Assistive Technology: Equipment and Supplies (incl PERS)	<input checked="" type="checkbox"/>	1,525	163	9	\$277.93	\$407,723
Assistive Technology: Communication Devices	<input checked="" type="checkbox"/>	-	-	-	\$0.00	\$0
Community Guide	<input checked="" type="checkbox"/>	161,830	737	220	\$10.54	\$1,708,956
Community Networking	<input checked="" type="checkbox"/>	162,074	118	1,368	\$17.67	\$2,852,362
Community Transition	<input checked="" type="checkbox"/>	226	147	2	\$3,512.94	\$1,032,804
Crisis Services	<input checked="" type="checkbox"/>	19,372	26	747	\$7.00	\$135,954
Assistive Technology: Home Modifications	<input checked="" type="checkbox"/>	4	4	1	\$1,680.95	\$6,724
In Home Intensive Supports	<input checked="" type="checkbox"/>	220,439	42	5,296	\$4.74	\$1,054,328
Home and Community Supports	<input checked="" type="checkbox"/>	-	-	5,447	\$5.16	\$0
In Home Skill Building	<input checked="" type="checkbox"/>	6,575,133	1,207	5,447	\$5.50	\$36,159,910
Individual Goods and Services	<input checked="" type="checkbox"/>	3,474	737	5	\$245.47	\$904,557
Natural Supports Education	<input checked="" type="checkbox"/>	8,365	19	452	\$10.32	\$88,628
Specialized Consultation Services	<input checked="" type="checkbox"/>	844	52	16	\$21.73	\$18,079
Assistive Technology: Vehicles	<input checked="" type="checkbox"/>	12	11	1	\$6,681.67	\$73,498
Financial Supports	<input checked="" type="checkbox"/>	10,924	737	15	\$117.10	\$1,294,541
GRAND TOTAL:						\$100,700,761
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						2081
FACTOR D (Divide grand total by number of participants)						\$48,391
AVERAGE LENGTH OF STAY ON WAIVER						324

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Waiver Year: Year 5						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care	<input checked="" type="checkbox"/>	1,285,746	238	5,399	\$3.75	\$4,818,600
Residential Supports	<input checked="" type="checkbox"/>	506,328	1,302	389	\$137.90	\$69,843,310
Day Supports	<input checked="" type="checkbox"/>	5,607,024	1,453	3,859	\$4.71	\$26,409,560
Supported Employment	<input checked="" type="checkbox"/>	785,075	476	1,648	\$9.68	\$7,593,450
Respite	<input checked="" type="checkbox"/>	2,915,485	2,413	1,208	\$4.63	\$13,496,000
Assistive Technology: Equipment and Supplies (incl PERS)	<input checked="" type="checkbox"/>	3,332	349	10	\$286.27	\$999,080
Assistive Technology: Communication Devices	<input checked="" type="checkbox"/>	-	-	-	\$0.00	\$0
Community Guide	<input checked="" type="checkbox"/>	442,061	1,974	224	\$10.85	\$4,797,610
Community Networking	<input checked="" type="checkbox"/>	354,181	254	1,395	\$18.20	\$6,448,800
Community Transition	<input checked="" type="checkbox"/>	618	395	2	\$3,618.33	\$2,858,480
Crisis Services	<input checked="" type="checkbox"/>	42,334	56	762	\$7.21	\$307,660
Assistive Technology: Home Modifications	<input checked="" type="checkbox"/>	9	8	1	\$1,731.38	\$13,850
In Home Intensive Supports	<input checked="" type="checkbox"/>	481,726	89	5,399	\$4.74	\$2,277,620
Home and Community Supports	<input checked="" type="checkbox"/>	-	-	5,553	\$5.16	\$0
In Home Skill Building	<input checked="" type="checkbox"/>	14,368,677	2,588	5,553	\$5.50	\$79,041,400
Individual Goods and Services	<input checked="" type="checkbox"/>	9,490	1,974	5	\$252.83	\$2,495,430
Natural Supports Education	<input checked="" type="checkbox"/>	18,280	40	461	\$10.63	\$196,010
Specialized Consultation Services	<input checked="" type="checkbox"/>	1,844	111	17	\$22.39	\$42,250
Assistive Technology: Vehicles	<input checked="" type="checkbox"/>	27	24	1	\$6,882.12	\$165,170
Financial Supports	<input checked="" type="checkbox"/>	29,839	1,974	15	\$120.61	\$3,571,260
GRAND TOTAL:						\$225,375,600
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						446
FACTOR D (Divide grand total by number of participants)						\$50,520
AVERAGE LENGTH OF STAY ON WAIVER						32

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