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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.

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

1. Request Information (1 of 3)

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

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

C. **Type of Request: new**

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

◉ **3 years** ○ **5 years**

☐ **New to replace waiver**

Replacing Waiver Number:

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)*

Draft ID: **NC.029.00.00**

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

Regular Waiver

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

01/04/17

1. Request Information (2 of 3)

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

☑ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

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

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☑ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of North Carolina's PRTF Waiver will be to provide an array of community based services, addition to Medicaid State Plan coverage, for children with Serious Emotional Disturbance who, in the absence of these waiver services would require hospitalization in a PRTF. (The cost neutrality of this waiver is based on expenditures for PRTF services delivered in PRTFs located in licensed hospitals.) The PRTF Waiver will allow an alternative to PRTF admission through the provision of community based services in the child's natural home or foster home setting. Goals are to reduce the length of stay in a PRTF when a child is placed, increase the number of children who can be diverted from placement with the support of the waiver services; provide high quality community based services and reduce expenditures for PRTF services.
North Carolina based the design of this waiver and choice of services on the experiences, outcomes and data gathered from the CMS PRTF Demonstration Waiver, authorized in the Deficit Reduction Act of 2005 and implemented from 2007 to 2012 and reported in the Final Evaluation in 2012 (amended in 2013.) This evaluation emphasized the importance of family, coordination of services across agencies and providers through a team approach, and active facilitation of the process. Therefore in implementing the PRTF Waiver, North Carolina will utilize this approach in providing services based on High Fidelity Wraparound principles that include:
1)prioritizing family engagement family driven, person centered planning, family choice in services and providers, family and youth peer support
2)the development of a single person centered plan and the coordination of this plan through active facilitation of members of the child and family team including family, foster families when indicated, involved agencies and providers;
3)increasing the child and family's self-sufficiency, optimism that they can once again manage their lives,
4)building the plan and interventions on the child and family's strengths
5)accessing high quality, evidence based, coordinated services; and
6)facilitating the involvement of social and informal support to assist the child and family in maintaining improvements following transition from waiver services.
Objectives of the waiver include
(1)increasing a family's and or foster family's engagement during a child's treatment for SED;
(2)aligning services and supports with a well-coordinated person centered plans
(3)increasing a child's and families competencies for maintaining the child in the community and thereby reducing recidivism into PRTFs;
(4) Improving clinical outcomes for children with SED as measured in part by decreased recidivism.

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

participants in the waiver have access to a Wraparound facilitator 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 and family are satisfied with the services and supports they are receiving. Services are delivered through a network of contracted community-based service providers that are charged with implementing waiver participants' ISPs by providing
Services and supports that enhance the participant's quality of life as defined by the participant. National accreditation is required of providers of waiver services.

3. Components of the Waiver Request

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

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

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ○ **No**
- ◉ **Yes**

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

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

Three MCO areas currently developing capacity in implementing High Fidelity Wrap"
Eastpointe
Cardinal two areas
Centerpoint
Smoky

year two

Cardinal
Eastpointe
Centerpoint
Smoky
Trillium
Sandhills
Partners
Alliance

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

5. Assurances

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

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

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

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

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

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

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

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

applicable) is:

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

the same household as the participant, as provided in **Appendix I.**

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
A PRTF Waiver stakeholder meeting was held on October 1, 2015. It was attended by 60 persons representing family and youth peer partner organizations, family and peer partners, providers, advocates, NC's Protection and Advocacy Organization, PIHPs, Department of health and Human Services staff from the Division of Social Services and Division of Mental Health, Developmental Disabilities and Substance Abuse. Additional Stakeholder groups will be held in the winter and spring of 2016.A PRTF Waiver stakeholder meeting was held on October 1, 2015. It was attended

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

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

7. Contact Person(s)

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

Last Name: Richard

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First Name:	Dave
Title:	Deputy Secretary for Medicaid
Agency:	Divison of Medical Assistance, NC Department of Health and Human Services (DHHS)
Address:	2501 Mail Service Center
Address 2:	
City:	Raleigh
State:	**North Carolina**
Zip:	27699-2501
Phone:	(919) 855-4105 **Ext:** ☐ **TTY**
Fax:	(919) 733-6608
E-mail:	dave.richard@dhhs.nc.gov

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

Last Name:	N/A
First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**North Carolina**
Zip:	
Phone:	**Ext:** ☐ **TTY**
Fax:	
E-mail:	

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Richard

First Name: Dave

Title: Deputy Secretary for Medicaid

Agency: Division of Medical Assistance, NC Department of Health and Human Services (DHHS)

Address: 2501 Mail Service Center

Address 2:

City: Raleigh

State: North Carolina

Zip: 27699-2501

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

Fax: (919) 733-6608

E-mail: dave.richard@dhhs.nc.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

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N/A

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   Behavioral Health Unit under the Clinical Policy Unit
   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

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Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   DMA contracts with the following entities which assist with administrative and operational activities:
   An External Quality Review Organization (EQRO) for quality reviews of the PIHPs;
   An MMIS contractor which assists with recipient enrollment and payment;
   An actuarial contractor which assists with setting the capitated payments to the PIHPs.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

DMA contracts with local management entities (LME) operating as prepaid inpatient health plans (PIHP)for the delivery of all Medicaid MH/IDD/SA services, including PRTF waiver services. LME/PIHPs conduct the following operational and administrative activities: utilization management and prior approval activities, provider network credentialing and enrollment and provider reimbursement.
LMEs, as defined in NC General Statute 122C, are area authorities, county programs, or consolidated human services agencies that are designated as "the locus of coordination" for publicly funded mental health, intellectual/developmental disabilities and substance abuse services in their respective catchment areas. Session laws 2011-264 and 2012-151 recently amended the statute to require the delivery of publicly funded services for individuals with mental illness, intellectual/developmental disabilities, and substance abuse disorders through LMEs under the authority of 1915(b)/(c) waivers.
The waiver responsibilities and performance requirements are set forth in a contract between the Division of Medical Assistance and each LME/PHIPs operating under the waivers.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Division of Medical Assistance conducts quarterly Interdepartmental Monitoring Team meetings on a quarterly basis. These meetings convene subject matter experts from both the Division of Medical Assistance and the Division of Mental Health, Substance Abuse, and Developmental Disability Services in the areas of customer services, provider network, clinical policy, claims processing, finance, and other areas as needed. On annual onsite operations performance review with a team from the State and Mercer occurs, as well as a review by the External Quality Review Organization (EQRO).

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Oversight and performance of the LME/PIHPs is performed 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. Contracts with the rate setting and external quality review contractors outline specific performance expectations which the contractor must meet. DMA contract managers assess deliverables and performance on an ongoing basis and implement corrective action plans as needed. The contract also outlines specific expectations and deliverables and performance assessment is monitored on an ongoing basis by DMA and DHHS contract managers.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance,

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complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
DMA ensures that PIHPs follow the ongoing monitoring process for enrolled providers.
Numerator: Number of PIHPs following the monitoring process for enrolled providers.
Denominator: Total Number of PIHPs

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

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

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	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
DMA ensures that PIHPs follow the Level of Care approval process. Numerator: Number of PIHPs following the Level of Care approval process Denominator: Total Number of LME/PIHPs

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
DMA ensures that PIHPs submit information in a complete and timely manner. Numerator: Number of PIHPs that submit performance measure information in a complete and timely manner Denominator: Total Number of PIHPs

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The PIHPs will address and correct problems identified on a case-by-case basis in accordance with their contracts with the DMA. The DMA requires a corrective action plan for the problems identified. The DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team (IMT). The

PIHP will notify the State immediately of any situation in which the health and safety of a beneficiary is jeopardized.

ii. **Remediation Data Aggregation**

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

	Frequency of data aggregation and

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐

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☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☑ Mental Illness					
	☐	Mental Illness			
	☑	Serious Emotional Disturbance	6	21	

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

This waiver is targeted to children and adolescents ages 6 to 21 years of age who have a serious emotional disturbance as evidenced by a DSM 5 diagnosis and a score of 5 on the Child and Adolescent Level of Care

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

When a participant in the SED waiver is approaching the age of 21, the Wraparound Facilitator and youth peer support specialist, if chosen by the participant to assist, will make a referral and set up transition meetings with an Adult Care Coordinator at the PIHP. The Care Coordinator can describe the services available to the youth and begin development of a transition plan. Since the adult behavioral services, such as psychosocial rehabilitation, ACT, supported employment, and adult peer support are available under the 1915(b)or (b) (3) concurrent waiver, desired services maybe implemented as he transitions off the SED Waiver. For continuity of care, a youth may decide to maintain his or her relationship with an outpatient or even family therapist. Prior to discharge it will be expected that the youth will have an approved Person Centered Plan with appropriate services through the adult system.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

◉ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

◉ **A level higher than 100% of the institutional average.**

Specify the percentage: 107

○ **Other**

Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

- **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

welfare can be assured within the cost limit:

Individuals may apply for the SED waiver by contacting the PIHP Access Center for 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 assessment including the CALOCUS and a 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 (MD or PhD) will review the assessments and make a determination as to whether the individuals needs can be met by the waiver up to the $40125cost limit. Written notice of the outcome of this assessment will be provided to the individual. If an individual is terminated from the waiver, the PIHP sends a written notice explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on the continuation of services during the appeal (if applicable) and contact information for questions and concerns.

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

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

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

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

☑ **Other safeguard(s)**

Specify:

If the individual's needs exceed the waiver, they would still be eligible for regular Medicaid services such as Inpatient Psychiatric or PRTF outside of the waiver.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	180
Year 2	228
Year 3	324

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

○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

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Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	150
Year 2	190
Year 3	270

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

If a child or adolescent
1)meets the criteria for admission into a Psychiatric Residential Treatment Facility, based on Medicaid Clinical Policy 8D-1,
2)has a CALOCUS Score of V or IV,
3)has a risk assessment indicating that presented risks can be safely managed in the community with intensive Wraparound Facilitation and support services and
4) and with his or her family, chooses to participate in the waiver, he or she will be selected for entrance when a waiver slot is available.

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Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount: [ ]

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

Specify:

[ ]

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Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

PIHP

- **Other**

Specify:

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

Persons performing initial evaluations of level of care for waiver participants are licensed psychologists, psychological associates, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists. 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 available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To be considered for the SED Waiver a child or adolescent must meet the following level of care criteria:
1)meets the criteria for admission into a Psychiatric Residential Treatment Facility, based on Medicaid Clinical Policy 8D-1,
Medicaid shall cover admission to Psychiatric Rehabilitation
Treatment Facilities when the beneficiary meets all of the following criteria:
a. The beneficiary demonstrates symptomatology consistent with a DSM-5, or any subsequent editions of this reference material, diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
b. The beneficiary is experiencing emotional or behavioral problems in the home, community or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.
c. The beneficiary demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.
d. The beneficiary has a history of multiple hospitalizations or other treatment episodes or recent inpatient stay with a history of poor treatment adherence or outcome.
e. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.
f. The family situation and functioning levels are such that the beneficiary cannot currently remain in the home environment and receive community based treatment, (in the absence of SED Waiver Services).

2)has a CALOCUS Score of IV: "Level 6: Secure, 24-Hour, Services With Psychiatric Management. Most commonly, these

services are provided in inpatient psychiatric settings or highly programmed residential facilities. If [illegible] could be met through the Wrap Around process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for
optimal care and that the transition to lower levels of care are smooth.
3)has a risk assessment indicating that presented risks can be safely managed in the community with intensive Wraparound Facilitation and support services available under the waiver .

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

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

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

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

When a family, PRTF or community provider requests SED Waiver Services from the PIHP, an authorization package must be submitted with a comprehensive assessment including psychosocial history, history of previous treatment, current mental and function status and a CALOCUS evaluation by a trained administrator with a CALOCUS Score of VI. The Level of Care Request will be evaluated by a licensed Utilization Reviewer at the PIHP. If the child is determined to meet Level of Care for PRTF admission based on criteria included in d above, a PIHP Care Coordinator will contact the family and discuss the options for participation in the SED Waiver.

The level of care reevaluation will be conducted by the same process.

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

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

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

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

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 maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of each LOC evaluation must be maintained by the PIHP for a minimum period of five years for those participants over the age of 18. For participants under the age of 18, documents must be maintained until their 23rd birthday. Level of care documents are maintained in the participant's record by the care coordinator and in the PIHP's administrative files.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

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

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

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☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LME/PIHP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signature on the Individual Service Plan

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

Data Aggregation and Analysis:

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

PIHP	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

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

Performance Measures

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

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

Performance Measure:
Proportion of Level of Care evaluations completed using approved processes and instrument. Numerator: Number of annual Level of Care evaluations completed using Level Of Care instrument/process for waiver participants. Denominator: Total number of waiver participants due for an annual plan

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

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

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	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The PIHPs will address and correct problems identified on a case by case basis and include the information in the reports to 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. The EQRO annual technical report provides detailed information on the regulatory compliance of the PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs). The report provides information about the quality, timeliness and accessibility of care furnished by the PIHPs, assesses strengths and weaknesses and identifies opportunities for improvement.

ii. **Remediation Data Aggregation**

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

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

Specify: LME/PIHP	☐ **Continuously and Ongoing** ☑ **Other** Specify: Semi-annually

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The PIHP 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. The PIHP makes interpreter services available to individuals with limited English proficiency.
The PIHP must comply with the DHHS Title VI Language Access Policy which ensures that individuals with limited English proficiency (LEP) have equal access to benefits and services for which they may qualify from entities receiving federal financial assistance. The policy applies to the North Carolina DHHS, all divisions/institutions within DHHS and all

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programs and services administered, established or funded by the Department, including subcontractors and ven

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	In Home Respite		
Statutory Service	Out of Home Respite		
Statutory Service	Wraparound Facilitation		
Other Service	Assistive Technology		
Other Service	Community Transition		
Other Service	Home and Community Living Skills		
Other Service	Individual Goods and Services/Flex Funds		
Other Service	Parent Peer Support		
Other Service	Parent Training and Counseling		
Other Service	Specialized Consultation		
Other Service	Youth Peer Support		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*
Respite is available twenty-four (24) hours/seven (7) days a week and may be provided in-home or out-of-home in following places:
I. Participant's home or private place of residence
II. In the community
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. 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service may not be used as a daily service in individual support. 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. 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.
Proposed limit of 450 15 minute units/year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employee of Agency
Agency	Behavioral Health Services Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Individual
Provider Type:
Employee of Agency
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certificate: First Aid; CPR;
Other Standard *(specify)*:
Provider:
Paraprofessional or Qualified Professional
Documented Training in Crisis Management

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider, PHIP
Frequency of Verification:
On hire by Provider, may be sampled by PIHP at least every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Agency
Provider Type:
Behavioral Health Services Provider Agency
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meets all criteria for enrollment in Medicaid. 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. Is an approved as a provider in the PIHP provider network: and assures Respite Employees are
• Are at least 21 years old and three years older than beneficiary.
• If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
• Criminal background check presents no health nor safety risk to participant
• Not listed in the North Carolina Health Care Abuse Registry
• Staff that work with participants must be qualified in CPR and First Aid
• Staff that work with participants must have a high school diploma or high school equivalency (GED)
• Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
• Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
• Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider Agencies

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PIHP

Frequency of Verification:
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):
Out of Home Respite

HCBS Taxonomy:

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

Service Definition *(Scope)*:
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 includes out-of-home services, inclusive of overnight, weekend care, and emergency care (family emergency based, not to include out-of-home crisis). 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.
Providers of overnight respite must be informed of the child's current status and all information required to ensure his or her health and safety.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum of 15 days per waiver year, with the maximum to be exceeded if the participant's caregiver continues to be in documented need for the service and total costs for all services for the participant under the waiver do not threaten the program's overall cost neutrality.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Placing Agency
Individual	Therapeutic Foster Parent

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out of Home Respite

Provider Category:
Agency
Provider Type:
Child Placing Agency
Provider Qualifications

License *(specify)*:
Must be licensed under Chapter 131 and under 10A NCAC 27G 70E, 70F and 70G.

Certificate *(specify)*:

Other Standard *(specify)*:
Must ensure licensure of therapeutic foster parents and their supervision by a Qualified Professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Division of Social Services, Licensure and Regulatory Section, and PIHP.

Frequency of Verification:
Every two years. and during PIHP monitoring at least every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out of Home Respite

Provider Category:
Individual
Provider Type:
Therapeutic Foster Parent
Provider Qualifications

License *(specify)*:
Licensed as a Therapeutic Foster parent under Chapter 131D and under 10A NCAC 70E, 70F and 70G.

Certificate *(specify)*:

Other Standard *(specify)*:
Must be current on all training for crisis management, child development, as required by licensure; must be informed of the child's current status and needs to ensure health and safety. Transportation cost is included in this service.

Verification of Provider Qualifications

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Entity Responsible for Verification:
DHHS DSS, CPA and PIHP may sample during monitoring at least every three years.
Frequency of Verification:
Per DSS rules and PIHP on monitoring at least every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Wraparound Facilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process. Children/youth who participate in the PRTF Waiver must receive WF. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and coordinates this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (grant, local system of care, etc.).
The WF is responsible for:
Developing the Person Centered Plan with the participant, family and Wraparound Team
- Working in full partnership with team members to develop a revised and annual plans of care;
- Overseeing implementation of the revised plan;
- Identifying providers of services or family based resources;
- facilitating Child and Family Team meetings; and
- Monitoring all services authorized for a child's care.

PRTF Waiver services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values. The Wraparound Facilitator:
- Offers consultation and education to all providers regarding the values and principles of the model;
- Monitors progress toward treatment goals;
- Ensures that necessary data for quality evaluation is gathered and recorded; and

• Ensures that all SED Waiver related documentation is gathered and reported to the independent assessor as per requirements.
The wraparound model involves 4 stages (Miles, Brunes, Osher & Walker, 2006):
1. Engagement: The family meets the WF. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the wraparound process. The WF engages other team members identified by the family—both natural supports and formal supports—and prepares for the first Child & Family team meeting.
2. Planning: The WF informs the team members about the family's strengths, needs, and vision for the future. The wraparound team does not meet without the family present. The Child & Family Team decides what to work on, how the work will be accomplished, and who is responsible for each task. Plan of Care (POC) development is facilitated by the WF and the WF is responsible to write the POC and obtain approval of the POC from the PIHP. The WF also facilitates a plan to manage crises that may occur.
3. Implementation: Family and team members meet regularly in accordance with the youth/family's needs. Meetings are facilitated by the WF who also assures that the family guides the family/team meetings. The team reviews accomplishments and progress toward goals and makes adjustments. The family and team members work together to implement plan.
4. Transition: As the family team nears the goals, preparations are made for the family to transition out of formal wraparound and PRTF Waiver services. The family and team decide how the family will continue to get support when needed and how wraparound can be re-started if necessary.The Wraparound Facilitator:
• Completes comprehensive assessment and periodic reassessment of the participant to determine service needs.
• Guides the engagement process by exploring and assessing strengths and needs;
• Facilitates, coordinates, and attends family and team meetings;
• Guides the planning process by informing the team of the family vision (no team meeting without family);
• Guides the crisis plan development, monitors the implementation and may intervene during a crisis;
• Authorizes and manages Flex Funding as identified in the Plan of Care;
• Reassesses, amends, and secures on-going approval of Plan of Care;
• Monitors cost-effectiveness of Medicaid services;
• Guides the transition of the youth from the PRTF Waiver;
• The wraparound facilitator will emphasize building collaboration and ongoing coordination among the caregivers, family members, service providers, and other formal and informal resources; and
• The wraparound facilitator will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One unit monthly; 12 units per year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Wraparound Facilitator
Agency	Community Behavioral Health Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Wraparound Facilitation

Provider Category:
Individual

DRAFT

Provider Type:
Wraparound Facilitator
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A Wraparound Facilitator:
• Must meet requirements as a qualified professional.
• Must Completion of Wraparound Facilitation training curriculum.
• Pass background check, the child and adult abuse registry checks, and motor vehicle screens.
• Receive ongoing supervision by a Licensed Mental Health professional who is certified as a Wraparound Supervisor.
Knowledge in:
(a) Types of functional limitations and health problems that may occur in clients with SED, or clients with other disabilities, as well as strategies to reduce limitations and health problems;
(b) Equipment and environmental modifications that may be required by clients with SED that reduce the need for human help and improve safety;
(c) Community-based and other services, including PRTF placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide respite and companion services;
(d)SED Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;
(e)SED Waiver requirements, as well as the administrative duties for which the client and family/caregiver will be responsible;
(f) Be Knowledgeable regarding assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
(g) Interviewing techniques;
(h) The client's and family/caregiver's right to make decisions about,
(i) The principles of human behavior and interpersonal relationships; and
(j) General principles of record documentation.

Skills in:
(a) Negotiating with clients, family/caregivers and service providers;
(b) Assessing, supporting, observing, recording, and reporting behaviors;
(c) Identifying, developing, or providing services to clients with SED; and
(d) Identifying services within the established services system to meet the client's needs.

Abilities to:
(a) Report findings of the assessment or onsite visit, either in writing or an alternative format for clients who have visual impairments;
(b) Demonstrate a positive regard for clients and their families;
(c) Be persistent and remain objective;
(d) Work independently, performing position duties under general supervision;
(e) Communicate effectively, orally and in writing; and
(f) Develop a rapport and communicate with persons from diverse cultural backgrounds. Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process. Children/youth who participate in the PRTF Waiver will automactically receive WF but may opt out by their choice. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and coordinates this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (grant, local system of care, etc.).
The WF is responsible for:
• Assuring the completion of a comprehensive re-assessment of the individual at least annually;
• Working in full partnership with team members to develop a revised and annual plans of care;
• Overseeing implementation of the revised plan;

• Identifying providers of services or family based resources;
• facilitating Child and Family Team meetings; and
• Monitoring all services authorized for a child's care.
PRTF Waiver services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values. The Wraparound Facilitator:
• Offers consultation and education to all providers regarding the values and principles of the model;
• Monitors progress toward treatment goals;
• Ensures that necessary data for quality evaluation is gathered and recorded; and
• Ensures that all PRTF Waiver related documentation is gathered and reported as per requirements.
The wraparound model involves 4 stages (Miles, Brunes, Osher & Walker, 2006):
1. Engagement: The family meets the WF. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the wraparound process. The WF engages other team members identified by the family—both natural supports and formal supports—and prepares for the first Child & Family team meeting.
2. Planning: The WF informs the team members about the family's strengths, needs, and vision for the future. The wraparound team does not meet without the family present. The Child & Family Team decides what to work on, how the work will be accomplished, and who is responsible for each task. Plan of Care (POC) development is facilitated by the WF and the WF is responsible to write the POC and obtain approval of the POC through the PIHP's utilization management process. The WF also facilitates a plan to manage crises that may occur.
3. Implementation: Family and team members meet regularly in accordance with the youth/family's needs. Meetings are facilitated by the WF who also assures that the family guides the family/team meetings. The team reviews accomplishments and progress toward goals and makes adjustments. The family and team members work together to implement plan.
4. Transition: As the family team nears the goals, preparations are made for the family to transition out of formal wraparound and PRTF Waiver services. The family and team decide how the family will continue to get support when needed and how wraparound can be re-started if necessary.
• The wraparound facilitator will emphasize building collaboration and ongoing coordination among the caregivers, family members, service providers, and other formal and informal resources; and
• The wraparound facilitator will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers.

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider and PIHP

Frequency of Verification:
On hire by both the Provider and the PIHP and by the PIHP at least every three years during monitoring.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Wraparound Facilitation

Provider Category:
Agency

Provider Type:
Community Behavioral Health Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
NC Wraparound

Facilitator Provider: Accredited Provider Agency
Provider standards are:
• Meets all provider requirements for enrollment in Medicaid, is credentialed and enrolled in the PIHP provider network.
• Agency accredited by a naturally recognized accrediting body: COA, CARF, JCAHO, or NCQA;
• Agency that has four (4) years of experience working with youth/children with SED.
• Agency employs a Wraparound Facilitator who has attended the trainings sanctioned by the Department (may include licensed mental health professional)and provides for supervision by a certified licensed Wraparound supervisor.

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP, per waiver requirements.

Frequency of Verification:
On enrollment and at least every three years during monitoring.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PE
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptatic
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 4:	**Sub-Category 4:**
14 Equipment, Technology, and Modifications	14032 supplies

Service Definition *(Scope)*:
Assistive Technology, Equipment and Supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of individuals. This service covers purchases, leasing, trial periods and shipping costs, and as necessary, repair/modification of equipment required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Monthly monitoring / connectivity charges may be covered when it is required for the functioning of the item / system. All items must meet applicable

standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the individual, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the person. This service may cover an evaluation, when the Medicaid State Plan option has been exhausted.

Medical necessity must be documented by the physician, physician assistant, or nurse practitioner, for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the physician, physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the Certificate of Medical Necessity/Prescription. Note: the Certificate of Medical Necessity/Prescription still must be completed and signed by the physician, physician assistant, or nurse practitioner.

Assistive Technology: Equipment and Supplies covers the following list of categories:
• Aids For Daily Living or Aids to increase Independent Living
• •Environmental Controls and Modifications

• Alert and Monitoring Systems
• Sensory Aids
• Communication Aids not covered by regular Medicaid State Plan

• Medical Supplies not covered by regular state plan formulary

For requests for assistive technology equipment the following additional information is required:
• a plan for how the person and family will be trained when needed on the use of the equipment;
• a written recommendation that includes a physician signature certifying medical necessity (not required for repair); or signature of other appropriate licensed professionals as determined by the PHIP policies
• shipping costs must be itemized in the request to be included, taxes are not coverable;
• other information as required for the specific equipment or supply request;
• quote(s) (PIHP determines how many quotes are required.)

For requests for supplies covered under this definition, the following additional information is required:
• A Statement of Medical Necessity completed by an appropriate professional that identifies the person's need(s) with regard to the equipment and supplies being requested. The Statement of Medical Necessity must state the amount and type of the item that a person needs.
• b. Supplies that continue to be needed at the time of the person's Annual Plan must be recommended by an annual Statement of Medical Necessity by an appropriate professional. The Statement of Medical Necessity must be updated if the amount of the item the person needs changes.

Exclusions:

Items that are not of direct or remedial benefit to the person are excluded from this service.
• Recreational items that would normally be purchased by a family are

excluded from this service.
• Computer desks and other furniture items are not covered.
• Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.
• Computer hardware will not be authorized solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the beneficiary.
• Hot tubs, Jacuzzis, and pools, are not covered.
• Items utilized as restraints are not coverable under the waiver.
Exclusions:
1. Items that are not of direct or remedial benefit to the person are excluded from this service.
2. Computer desks and other furniture items are not covered.
3. Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.
4. Computer hardware will not be authorized solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the beneficiary.
5. Hot tubs, Jacuzzis, pools, are not covered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The service is limited to expenditures of $1000 over the life of the waiver period.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Commercial/Retail Businesses
Provider Qualifications
License *(specify)*:
Applicable state/local business license
Certificate *(specify)*:

Other Standard *(specify)*:
Meets applicable state and local requirements and regulations for type of device that the business is providing.

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP

Frequency of Verification:
Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Providers

Provider Qualifications

License *(specify)*:
Applicable state/local business license

Certificate *(specify)*:
DMA enrolled vendor

Other Standard *(specify)*:
Meets applicable state and local requirements and regulations for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP

Frequency of Verification:
Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Alert Response Centers

Provider Qualifications

License *(specify)*:
Applicable state/local business license

Certificate *(specify)*:

Other Standard *(specify)*:
Response centers must be staffed by trained individuals, 24 hours/day, 365 days/year
Meets applicable state and local requirements and regulations for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP

Frequency of Verification:

DRAFT

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual

Provider Type:
Specialized Vendors

Provider Qualifications

License *(specify):*
Applicable state/local business license

Certificate *(specify):*

Other Standard *(specify):*
Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP

Frequency of Verification:
Prior to first use

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

DRAFT

Service Definition *(Scope):*
One-time, set-up expense for youth and young adult participants to facilitate their transition from a PRTF stay or long term hospitalization to a non-provider owned, private living arrangement where the participant is directly responsible for his or her own living expenses. Such assistance may be sought while the participant's family is in the process of securing other benefits (e.g. SSI) or resources that may be available to assume these obligations and provide needed assistance. 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.
Covered transition services are:
1) Security deposits that are required to obtain a lease on an apartment or home;
2) Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens;
3) Moving expenses required to occupy and use a community domicile;
4) Set-up feeds 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.

Additionally, non-recurring expenses to facilitate independent transportation opportunities, such as driver's license, driver's training or vehicle registration in instances where a vehicle has been donated are allowable.

Community transition expenses are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. These supports may be provided only once to a waiver participant. These services are available only during the three-month period that commences one month in advance of the participant's move to an integrated living arrangement. The payment rate is individually determined based on the costs for the specific goods and services. This rate is based on a review of comparable priced goods or services.
Limits:
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Funds must be prior authorized and used for transiting into independent living or gaining independence in functioning in the community.
Waiver Lifetime limit of $2000 per participant.
Exclusions: 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. Can be accessed only one time from either the 1915 b or 1915 c waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Behavioral Health Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency

DRAFT

Provider Type:
Community Behavioral Health Services Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The provider must be established as a legally constituted entity capable of meeting the requirements for enrollment in Medicaid. Must be credentialed and enrolled in the PIHP.
Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the state designated accrediting agencies.
Verification of Provider Qualifications
Entity Responsible for Verification:
PIHP
Frequency of Verification:
On enrollment in the PIHP and no less than every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home and Community Living Skills

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
This service is designed to provide both children and youth who are at imminent risk of PRTF placement or who are stepping down from hospitalization or PRTF placement an opportunity to learn new skills or to enhance skills they already have that will help them to function and maintain successfully in their homes, schools, and/or communities. These skills may include Independent Living skills for youth transitioning to adulthood, as well as

behavioral skills for younger children whose participation in community activities has been limited in the past due to behavioral crises. Community Living Skill-building services are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals of community inclusion and remaining in their home. The supports may be provided in the participant's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.) based on the individual's needs as documented in the plan of care. This service provides assistance to the family in the care of their child, while facilitating the child's independence and integration into the community. The services, as identified in the plan of care, are provided in community settings when integration into the community is an identified goal. Provider can do direct skill-building with child/youth in areas related to activities of daily living (such as personal hygiene), task/responsibility management, or problem-solving. The service may also promote communication, relationship-building and other socialization skill-building as well. These supports must be provided directly to, or on behalf of, the child/youth, enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
PROPOSED LIMIT: 410 15 minute units/year

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Professional
Agency	Community Behavioral Health Services Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home and Community Living Skills

Provider Category:
Individual

Provider Type:
Qualified Professional

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet requirements as a qualified professional
• 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 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
• Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider Agency, PIHP

Frequency of Verification:
On hiring the staff and by PIHP who may sample employees qualifications at least every three years during monitoring.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home and Community Living Skills

Provider Category:
Agency

Provider Type:
Community Behavioral Health Services Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The provider must be established as a legally constituted entity capable of meeting the requirements for enrollment in Medicaid. Upon enrollment with the PIHP, the organization must have achieved national accreditation with at
least one of the state designated accrediting agencies. Must be approved as a provider in the PIHP provider network and must assure that staff providing this service:
• Meet requirements as a qualified professional
• 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 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
• Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
• Enrolled to provide crisis services or has an arrangement with an enrolled crisis services provider to respond to participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however
•

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider Agencies
PIHP

Frequency of Verification:
Provider verifies employee qualifications at the time employee is hired
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample

of employee qualifications, at a frequency determined by the PIHP, no less than every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Goods and Services/Flex Funds

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Flex Funds may be used to purchase a variety of one-time or occasional goods and/or services needed when no other funding source is available. Service/ good must be directly related to and described in the PCP. It must be tied directly to a specified documented need with rationale as to how expenditure will assist the participant to remain in the home and/or community. The rationale must also be related to one or more of the following outcomes:

1)success in school
2)living at the person's own home or with family;
3)development and maintenance of personally satisfying relationships;
4)prevention of or reduction in adverse outcomes, (arrests, delinquency, victimization and exploitation;) and/or
5)becoming or remaining a stable and productive member of the community.

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

Expenditure may not exceed $1200/year

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Behavioral Health Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services/Flex Funds

Provider Category:
Agency
Provider Type:
Community Behavioral Health Services Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Utilization of funds must be part of the Individualized Person Centered Plan and prior authorized by the PIHP.
Provider Agency must meet all criteria for enrollment in Medicaid and be an approved and credentialed as wraparound facilitation provider by the PIHP.
Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Verification of Provider Qualifications
Entity Responsible for Verification:
PIHP
Frequency of Verification:
At least every three years during routine monitoring.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Parent Peer Support

HCBS Taxonomy:

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

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09 Caregiver Support	09020 caregiver counseling and/or training

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

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

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

Service Definition *(Scope)*:
Parent Peer Specialists or Parent Partners provide support to caregivers and participants and planning teams that assist participants in developing social networks and connections within local communities. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The purpose of this service is to promote self-determination, increase engagement and participation in their service planning. Parent Peer Support Services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the family/caregivers and participant's needs in addition to paid services.

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 caregiver and participant throughout the service delivery process. Community Guide services are intended to enhance, not replace, existing natural and community resources.

Specific functions are:
1. Assistance in forming and sustaining a full range of relationships with natural and community supports the caregiver and participant to address the family's needs.
2. Developing a relationship with the caregiver and participant in order to understand the family's need for assistance with advocacy and development of natural supports.
3. Support to develop social networks with community organizations to increase the caregiver and participant's opportunity to expand valued social relationships and build connections within the family's local community.
4. Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving PCP goals; this includes social and educational resources, as well as natural supports.
5. Education conducted in a culturally sensitive, non judgmental manner which assists the family in problem solving and decision making.
6. Advocacy and collaborating with other individuals and organizations on behalf of the participant.
7. Supporting the person in preparing, participating in and implementing plans of any type (IEP,PCP)).
8. Supporting, modeling, and coaching caregivers to assist with their engagement with their planning and support and services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Proposed Limit: 480 units/year. (15 minute units)

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

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

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

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

Provider Specifications:

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Provider Category	Provider Type Title
Agency	Community Behavioral Health Services Provider Agency
Individual	Parent Partner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Peer Support

Provider Category:
Agency
Provider Type:
Community Behavioral Health Services Provider Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Established as a legally constituted entity capable of meeting the requirements of the for enrollment in Medicaid and be credentialed and enrolled in the PHIP.
Verification of Provider Qualifications
Entity Responsible for Verification:
PIHP
Frequency of Verification:
On enrollment and at least ever three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Peer Support

Provider Category:
Individual
Provider Type:
Parent Partner
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Holds a National Certification in Parent Peer Support
Other Standard *(specify):*
Must have lived experience as a primary caregiver for a child who has serious emotional disturbance; must be able to serve as active team member on the Wraparound team for a child and family and work with the parents to support the parent in working towards the goals in the treatment plan.
Criminal background check presents no health or safety risk to participant
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the participants as described in the Individual Support Plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
Provider Agency on hiring and the PIHP.

Frequency of Verification:
Provider Agency the PIHP during monitoring every three years.

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Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Parent Training and Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Parent Training and Counseling is designed to provide in home or community,Family/Natural Support/Caregivers with education and/or training that will enhance their ability to provide a safe and supportive environment; to develop specific problem-solving skills; and to implement effective intervention/strategies that will support child/youth's success in home and community. Trainers who provide this service may use curriculum-based training. This service may provide information regarding the nature and impact of the serious emotional disturbance upon the individual; provide education and training on intervention/strategies; and provide education and technical assistance in carrying out a child's behavior plan. 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 participant's natural support network. The expected outcome of this training is to develop and support greater access to the community by the beneficiary by strengthening his or her natural support network.

Parent/Caregiver Training provides training and education to develop or enhance families' and the participant's natural support network capacities and skills in the following areas:

- Decision-making capacity of the natural support network,
- Understanding the nature and impact of the participant's emotional/behavioral challenges and the role and impact of medication;
- Safe and effective application of intervention/strategies; and/or
- Specific problem-solving skills and coping mechanisms for participant's symptom/behavior management.

The 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 and be specified in the participant's plan of care. Training provider may partner with Peer Support practitioners to support family in practicing the skills as first taught by the professional staff.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Proposed Limit: 208 units year or equivalent in class or conference.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Behavioral Health Services Provider Agency
Individual	Individual Associate or Licensed Mental Health Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Training and Counseling

Provider Category:
Agency

Provider Type:
Community Behavioral Health Services Provider Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Provider Agencies must have achieved national accreditation with at least one of the designated accrediting agencies.
Must meet all requirements for enrollment in Medicaid; must be credentialed and enrolled in a PIHP.
Must be established as a legally constituted entity capable of meeting the requirements of the PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Frequency of Verification:
On enrollment as a Wavier provider, and at least every three years subsequently

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Training and Counseling

Provider Category:

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Individual

Provider Type:
Individual Associate or Licensed Mental Health Practitioner
Provider Qualifications
License *(specify):*
-Individual must be licensed as a Licensed Clinical Social Worker, Licensed Psychologist, Licensed Professional Counselor, Licensed Psychiatric Nurse Practitioner, Licensed Marriage and Family Therapist
Certificate *(specify):*

Other Standard *(specify):*
Must have direct practice and experience in working with children and families and be an active member of the child and family Wraparound Team.

Criminal background check presents no health or safety risk to participant
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the participants as described in the Individual Support Plan
Verification of Provider Qualifications
Entity Responsible for Verification:
Provider verifies employee qualifications at the time employee is hired
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Frequency of Verification:
Provider Agency and PIHP conducts a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11090 physical therapy
Category 4:	**Sub-Category 4:**

DRAFT

11 Other Health and Therapeutic Services	11080 occupational therapy

Service Definition *(Scope)*:
Specialized Consultation Services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy, nutrition, and other licensed professionals who possess experience with individuals with Serious Emotional Disturbance (SED) to assist family members, support staff and other natural supports in assisting individuals with serious emotional disturbance. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan.

Activities covered are:
• Observing the individual to determine needs;
• Assessing any current interventions for effectiveness;
• Developing a written intervention plan, which may include recommendations for assistive technology/equipment, home modifications, and vehicle adaptations or therapeutic exercises / interventions / strategies. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, direct support professionals and natural supports;
• Developing a written intervention plan, which may include preventative strategies, behavioral interventions and strategies. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, direct support professionals and natural supports;
• Training and technical assistance of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan;
• Observe, record data and monitor implementation of therapeutic interventions/support strategies;
• Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan;
• Revision of the intervention plan as needed to assure progress toward achievement of outcomes
• Participating in team meetings; and/or
• Tele-consultation through use of two-way, real time-interactive audio and video to provide behavioral and psychological care when distance separates the care from the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Consultative Services may not duplicate services provided through Natural Supports Education. Proposed limit 90 units/year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Independent Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Consultation

Provider Category:
Agency

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Provider Type:
Provider Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
-NC G.S.122C, as appropriate
-Staff must have a license in Clinical Social Work, Psychology, Marriage and Family Therapy, Professional Counseling or hold an appropriate license for physical therapy, occupational therapy, speech therapy, behavioral analysis (licensure subject to psychology board implementation date) and nutrition; state certification for recreational therapy; board certified behavior analyst-MA; master's degree and expertise in augmentative communication; state certification in assistive technology
-Criminal background check presents no health or safety risk to participant
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the participants as described in the Individual Support Plan
Verification of Provider Qualifications
Entity Responsible for Verification:
Provider Agencies
PIHP
Frequency of Verification:
Provider verifies employee qualifications at the time employee is hired
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Consultation

Provider Category:
Individual
Provider Type:
Independent Practitioner
Provider Qualifications
License *(specify):*
Licensure specific to discipline, if applicable
Certificate *(specify):*
Certification or registration specific to discipline, if applicable
Other Standard *(specify):*
• Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology, behavioral analysis (licensure subject to psychology board implementation date) and nutrition; board certified behavior analyst–MA; master's degree and expertise in augmentative communication; state certification in assistive technology and state certification in recreation therapy
• Criminal background check presents no health or safety risk to participant
• Not listed in the North Carolina Health Care Abuse Registry
• Qualified in the customized need of the participants as described in the Individual Support Plan
Verification of Provider Qualifications
Entity Responsible for Verification:
Provider agency and or PIHP
Frequency of Verification:
At time of initial review and at least every three years thereafter.

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Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Youth Peer Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Youth Support and Training services are child/youth centered support services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The Youth support and training services will have a recovery focus designed to promote skills for coping with and managing presenting emotional and behavioral problems while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's individualized PCP. The structured, scheduled activities provided by this service emphasize the opportunity for youth to support other children and youth in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Youth Support and Training is a face-to-face intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of Youth Support and Training contacts must occur in community locations where the person lives, works, attends school and/or socializes. This service may include the following components:

a. Helping the child/youth to develop a network for information and support from others who have been through similar experiences.

b. Assisting the child/youth to regain the ability to make independent choices and take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treating with their clinician. Assist participants in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable participants to independently direct and manage their lives

c. Assisting the child/youth to identify and effectively respond to or avoiding identified precursors or triggers that maintain or increase functional impairments.

d. Assist the child/youth with the ability to address and reduce the following behaviors: reducing reliance on Youth Support and Training, over time, rebelliousness, early initiation of anti-social behavior (e.g., early initiation of drug use), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement, and intentions to use drugs

e. Assist with developing skills and resources and using tools related to communicating recovery strengths,

communicating health needs/concerns, self-monitoring progress), and creating a wellness/resiliency/recovery plan

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Proposed Limit: 216 15 minutes unit, annually or these maybe supplemented by units from Home and Community Living Skills, depending on the needs of the child or youth.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Youth Peer Support Specialist
Agency	Community Behavioral Health Serivces Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Peer Support

Provider Category:
Individual

Provider Type:
Youth Peer Support Specialist

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Must be eligible for National Certification as a Youth Peer Specialist.

Other Standard *(specify)*:
a. Has lived experience of successfully navigating and transitioning from the children's systems of care to independent adulthood. Training, education or skills necessary to meet the participants needs for Youth Peer Support Services are demonstrated by a minimum of a high school diploma and/or a GED;
b. Has completed or is working on youth peer support certification.
c. Is knowledgeable about resources in any local community in which the provider is a Youth Peer Support;
e. Has demonstrated connections to the informal structures of any local community in which the provider is a Youth Peer Support;
f. Understands Youth Peer Support services, strategies for working effectively and communicating clearly with individuals with mental illness and their families/ representatives, and waiver participant direction service delivery requirements
Must be at least 21 years of age and 3 years older than any child or adolescent who is being served.
Must be supervised by Wraparound Team supervisor
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

Verification of Provider Qualifications

Entity Responsible for Verification:

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By Agency on hire and by PIHP.
Frequency of Verification:
On going by Agency and at least every three years by PIHP during provider monitoring.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Peer Support

Provider Category:
Agency

Provider Type:
Community Behavioral Health Serivces Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Provider must be established as a legally constituted entity capable of meeting the requirements of the enrollent in Medicaid; must have achieved national accreditation with at least one of the designated accrediting agencies.
Must must be credentialed and enrolled in a PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:
On enrollment with the PIHP and at least every three years thereafter during monitoring.
Frequency of Verification:
See above.

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Community Behavioral Health Services Agency through Certified Wraparound Facilitators.

Appendix C: Participant Services

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

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The state's contract with the PIHP, in accordance with 42 CFR § 455.106, requires the PIHP to require all providers to disclose any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The PIHP must report such disclosures to DMA within 20 working days from the date the PIHP receives such disclosures. Pursuant to 42 CFR § 455.106(b)(1), DMA will report such disclosures to HHS-OIG within 20 working days after notification by the LME-PIHP.
Criminal background checks must be conducted prior to hiring the employee in all situations described below. As provided by NC G.S. 122C-80, criminal background checks must be conducted on all prospective employees of licensed MH/DD/SAS provider agencies who may have direct access to individuals served. PIHP licensed contract agencies must comply with this law. This includes direct care positions, administrative positions and other support positions that have contact with individuals served. When prospective employees have lived in North Carolina for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.
North Carolina's SED Waiver service provider qualifications, including those for unlicensed provider agencies who contract to provide services under this waiver include requirements for conducting conduct criminal background checks on all prospective employees who may have direct access to individuals served. The PIHP conducts criminal background checks on independent practitioners. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. National criminal record checks may be completed by private entities (defined as a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency in each of the States) while State criminal history record checks may be completed by a county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank. In addition, a State criminal history record check may be completed by a private entity (defined as a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency). A provider of unlicensed services shall not employ an applicant who refuses to consent to a criminal history record check required by this waiver.
The PIHP reviews the provider agency 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.

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

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

G.S. 131E-256, 10 A NCAC, requires the PHIP to require providers to perform a Health Care Registry screen at the time that they apply or renew their applications for Medicaid participation or at any time on

request. The LME-PIHP must report such disclosures to DMA within 20 working days from the date the PIHP receives such disclosures. DMA will report such disclosures to the HHS-OIG within 20 working days of notification by the PIHP.

Abuse registry screenings must be conducted prior to hiring the employee in all situations discussed below. As provided by NC General Statute 131E-256, the DHHS Division of Health Service Regulation maintains an abuse registry, called the Health Care Personnel Registry. As required by NCGS 131-E-256, licensed agencies and unlicensed providers of community based services for persons with SED who contract with the PIHP must conduct abuse registry screenings of prospective employees for positions who have direct access to individuals receiving services. Information from both the Nurse Aide Registry and the Health Care Personnel Registry is available to the general public and all health care providers via the Internet and through a 24 hour telephone voice response system through the Division of Health Service Regulation at http://www.ncdhhs.gov/dhsr/hcpr/index.html.

The PIHP reviews the provider agency 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.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ○ **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).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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

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

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and

above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

  Specify:

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

Under its risk contract with 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

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

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Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of new licensed providers that meet licensure, certification and/or other standards prior to their furnishing waiver services. Numerator: Number of new licensed providers reviewed who meet the requirements to furnish waiver services. Denominator: Total number of new licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider applications and evidence of licensure/certification

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

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that applies):	
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: PIHPs	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan. Numerator: Number of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan. Denominator: Number of non-licensed, non-certified providers required to submit a corrective action plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring Protocol and Tools

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

☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe. Numerator: Number of provider agencies monitored wherein all staff have completed all mandated training, excluding restrictive interventions, within the required timeframe. Denominator: Number of provider agencies monitored.

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring Protocol and Tools

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The PIHPs address and correct problems identified on a case by case basis and include the information in reports to DMA and the IMT. Issues with providers are often identified through consumer complaints/grievances which are reported to the DMA quarterly by the PIHPs. The PIHPs may require the provider to implement a corrective action plan. Depending on the seriousness of the provider issue and/or the results of the corrective action plan, the PIHP may terminate the provider from the network.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

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

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

The majority of the services provided under this waiver will be delivered in the child's home, in a foster home, or in the community during the provision of Home and Community Based Skill Building services. When a child is placed in foster care, the Child Placing is not a waiver provider, but the foster home is serving as a site for waiver services. The Child Placing Agency will be required to review the foster home to assure that HCB setting requirements are met. When a CPA is providing out of home Respite Services in a Therapeutic Foster home, it will be serving as direct provider of waiver services and will be responsible for assuring the HCB standards are met.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan (ISP)

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

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

  The Wraparound Facilitator, who must be certified as a High Fidelity Wraparound Facilitator and meet the criteria of a Qualified professional as defined in North Carolina Administrative Code at 10A NCAC 27G .0104, will be responsible for Service Plan Development through the Wraparound Team process, which is driven by the needs and choices of the child and family.
- ☐ **Social Worker**

  Specify qualifications:
- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

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

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

Yes, Community Behavioral Health providers who are credentialed to provide Wraparound Facilitation, will be allowed to provide other services. In order to provide safeguards to ensure that the services plan development is conducted in the best interest of the participant, the waiver will require that the assessment and service recommendations be delivered by an independent practitioner who is not employed by the Wraparound Provider Agency. Additionally, the PIHP will review the requested services for appropriateness during the Utilization/Authorization Process. All SED Waiver services must be prior authorized.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

(a)A variety of person centered toolkits are available to gather information and enable the participants to share information with the Wraparound team. The participant can complete the toolkit with the assistance of the Parent Partner or Parent Trainer as needed. Based on the unique needs of the participant, a decision can be made to use one toolkit, multiple toolkits or none at all.
(b)The participant, the Parent Partner and Wraparound Facilitator will 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 Wraparound Facilitator will ensure that the person is invited to the ISP meeting as well.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

ndividual Support Plan (ISP):

The timing of service plan is specific to the type of service plan (initial plan of care, annual updates, or revisions). The following outlines the type of service plan and the timelines associated with them:

Initial Plan of Care – Any person entering the SED Waiver must have an initial level of care determination completed prior to the start of the care planning process. Once the level of care determination is complete, the service plan must be completed within 15 calendar days. Once the initial plan of care is complete, the participants annual plan due date is identified.

While the Wraparound Facilitator, the family, and the Parent Partner will be assessing the effectiveness of the plan and services on an ongoing basis, the SED Waiver requires updates every six months from implementation of services.

Revisions to the Individual Support Plan – Revisions are made to the Individual Support Plan whenever the participant's life circumstances change. This may occur often or rarely, depending on the individual. This includes any change in the amount, duration or frequency of a service. A temporary, one time change in approved service does not require a plan revision. For example, if the participant goes on vacation and needs to suspend services for two weeks, a revision is not needed. The participant's planning team may use common sense and discretion in applying this exception, and an explanation of the change must be documented in the individual's record. Revisions are also made to the Individual Support Plan when the cost of a service changes.

The Individual Support Plan (ISP) is updated at least annually, and revisions are made as often as necessary to reflect

changes in the participant's life circumstances or service needs. Revisions may be made frequently or rarely, depending on the participant and individual life circumstances. Examples of changes that may necessitate a revision include accomplishment of a goal, lack of progress on a goal, change in living arrangement, increased medical needs, change in employment status, change in educational status, increased or decreased supervision needs, behavioral changes, etc. Relevant assessments are also updated at this time, as appropriate. Changes in short term goals and intervention strategies do not require an ISP update or revision.

Any member of the person centered planning team may suggest that the ISP be updated or revised. The Wraparound Facilitator is responsible for monitoring the ISP, and reviews goals at a minimum frequency based on the target date assigned to each goal. Goals may be, and often are, reviewed more frequently based on the needs of the individual. The Wraparound Facilitator also maintains close contact with the participant, the legally responsible person or parent or guardian (if applicable), Parent Partner providers, and other members of the person centered planning team, noting any recommended revisions needed. This ensures that changes are noted and updates are effectuated in a timely manner.

Care Coordination:

The Wraparound Facilitator will be providing Care Coordination under this waiver. The Wraparound Facilitator must be Certified and Supervised by a Certified Wraparound Supervisor. They must meet, additionally, qualifications as a Qualified Professionals under the North Carolina credentialing system and are competent in the person centered planning process. The Wraparound Facilitator is responsible for facilitating the person centered planning process and is responsible for the preparation of the Individual Support Plan. The Facilitator works with the participant and/or the legally responsible person to access services such as Parent Peer Support and Parent Trainer to develop skills in leading the planning team and to identify its membership. The participant may choose additional members for the person centered
planning team. The Wraparound Facilitator supported by the Parent Partner, if the family's requests this service, assists the participant in scheduling the meeting and inviting team members to the meeting at a time and location that is desired by the participant. Each team member receives a notification of the meeting.

ISP Development -
The ISP is developed through a Wraparound person centered planning process led by the participant and/or parent or legally responsible person for the participant. 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 his or her family 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 participant and parents regarding the SED waiver. The participant's Wraparound Facilitator is available to answer any questions that the participant/family may have regarding available services. The Facilitator works with the participant/family and the Wraparound Team to develop the ISP. That Facilitator determines with the participant and/or legally responsible person assist them in leading 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 parent or legally responsible person as clinically indicated.
The initial ISP, with an authorized signature(s), is completed and submitted to the PIHP for approval no later than 15 days from the admission into the waiver. 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.

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 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 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.

The SED Waiver will be implementing the use of the Child and Adolescent Functional Assessment Scale for both service planning and for measurement of progress. It will be administered by an independent licensed practitioner, who is trained in the use of the CAFAS, at entry into the SED Waiver, at six months and at discharge. The CAFAS provides a data base for entry and analysis of the findings that will be used to guide treatment and assess effectiveness of services.

The Wraparound Individual Support Planning Meeting:

The participant and Wraparound Facilitator 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 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 every 6 months, 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 Wraparound Facilitator reassesses each participant's needs on an ongoing services and develops an updated PCPISP continued need review (CNR), based on that reassessment. The Facilitator 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 Wrap Facilitator to resolve these issues.

The Wrap Facilitator 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 Wrap Facilitator will inform the participant of the right to request a fair hearing. The Wrap Facilitator will assist the participant and the family through the Fair Hearing process. The Wrap Facilitator 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 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 Wrap Facilitator makes sure that the ISP contains a plan for coordinating services, including the Wrap Facilitator's responsibility for overall plan coordination of waiver and other services.

The service plan is subject to at least monthly and review and update to assess the appropriateness and adequacy of the services as participant needs change. The Wrap Facilitator will work with participants and their family 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).

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

Updates/Changes to the ISP:

The Wrap Facilitator 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. 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.

Implementation -

The responsibility for implement the Individual Service Plan (ISP) is shared among all members of the person centered planning team. The participant and family directs the planning process to the extent he/she desires, and works to reach the goals identified in the ISP. Service providers are responsible for developing intervention strategies and monitoring progress at the service delivery level. The service provider ensures that staff are appropriately qualified and trained to deliver the interventions necessary to support the accomplishment of goals. The provider is also responsible for clinical supervision of staff. Other team members are responsible to the extent identified in the ISP. The Wrap Facilitator is ultimately responsible for monitoring and overseeing the implementation of the ISP. The Wrap Facilitator monitors the provision of services through observation of service provision, review of documentation and verbal reports. The Wrap Facilitator maintains close contact with members of the person centered planning team to ensure that the ISP is implemented as intended.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

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

Support needs and potential risks that are identified during the assessment process are addressed in the ISP, which includes a crisis plan as applicable. Strategies to mitigate the risk reflect 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

The Wrap Facilitator along with the support services staff, following the PIHP policy, assists the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP. The Wrap Facilitator 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 Wrap Facilitator provides any additional information that may be helpful in assisting them to choose a provider. Arranging provider interviews is facilitated by the Wrap Facilitator on behalf of the participant. Once the participant has selected a provider, their choice of provider is documented in the service record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

The PIHP approves ISPs following a process approved by the DMA, the State Medicaid agency. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

PIHP

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The Wrap Facilitator is responsible for monitoring the implementation of the ISP. Services are implemented within 15 days of ISP approval. The Wrap Facilitator 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
The services meet the needs of the participants, that the back-up staffing plans are documented
(3) 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

Wrap Facilitator 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, to meet their health and safety needs.
(2) Participants who choose the individual family directed service option receive face-to-face monitoring visits monthly.

(3) At least one service is utilized monthly, per waiver eligibility requirements.
(4) 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.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Proportion of Person Centered Plans in which the services and supports reflect the individual's assessed needs and life goals. Numerator: Number of Person Centered Plans in which services and supports reflect the individual's assessed needs and goals. Denominator: Total number of Person Centered Plans for individuals

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Signed Person Centered Plan

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Proportion of person centered plans that are completed in accordance with the State Medicaid Agency's requirements. Numerator: Total number of reviewed person centered plans that are in accordance with the State Medicaid Agency's requirements. Denominator: Total number of person centered plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: PIHP	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Proportion of individuals for whom an annual plan and/or needed update took place. Numerator: Number of individuals for whom all annual Person Centered Plans and needed updates took place. Denominator: Total number of waiver beneficiaries requiring an annual Person Centered Plan or update.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

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Proportion of individuals who are receiving services in the type, scope, amount and frequency as specified in the Person Centered Plan. Numerator: Number of waiver individuals reviewed who received services in the type, scope and frequency listed in the Person Centered Plan. Denominator: Total number of waiver individuals reviewed.

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

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

Data Aggregation and Analysis:

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

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Proportion of individuals reporting they have a choice between providers. Numerator: Number of Person Centered Plans for waiver individuals that indicate the individuals were given a choice of providers. Denominator: Total number of Person Centered Plans for waiver individuals annually

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signature on individual support plans

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

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	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The LME/PIHPs will address and correct problems identified on a case by case basis and include the information in a 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 LME/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.

ii. **Remediation Data Aggregation**

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

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

Specify:

☐ **Continuously and Ongoing**

☐ **Other**

Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s)

that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The NC SED waiver will operate concurrently with a 1915(b) waiver through prepaid inpatient health plans (PIHP). All waiver applicants/participants are notified of their right to request a fair hearing by the PIHP in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Participants are required to access the PIHP's internal appeal process before requesting a hearing with the State, as required under the concurrent 1915(b) waiver, NC Mental Health, Developmental Disabilities and Substance Abuse Services Health Plan. Upon enrollment in the 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.RO3), section A, Part IV-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 which are conducted by the NC Office of Administrative Hearings. When the suspension, reduction or termination of service is appealed, participants may continue to receive services up through the final decision by the Office of Administrative Hearings (OAH) as long as they meet the appeal deadlines, the original period covered by the authorization has not expired and the participant requests continuation of the service. When the LME/MCO makes a denial based on Level of Care, appeal rights are preserved. Copies of all notices and documentation of decisions are maintained by the agency from which they originate. The PIHP maintains records on the local appeal and the OAH maintains records on the formal hearing. Appeal decisions are loaded into the PCG system and monitored monthly by DMA.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

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

The 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 the contract between the State and PIHP. 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.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

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

The North Carolina Administrative Code (NCAC) at 10A NCAC 27G.0609 requires local management entities (operating as PIHPs for waiver purposes) to report to the DHHS Division of MH/DD/SAS all complaints (grievances under 42 CFR 438 Subpart F) made to the PIHP not less than quarterly. The submission of the PIHP complaint report is included in the contract between the PIHP and the Division of MH/DD/SAS. Four documents provide procedures and instructions relative to the complaint process:
1. Guidelines for the complaint reporting system
2. Customer service collection forms
3. Quarterly complaint report
4. Complaint reporting instructions

A copy of the quarterly complaint report is shared with the PIHP 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
(11) Quality of care
(12) Service coordination between providers
(13) Other to include any complaint that does not fit the previous areas.
Information is recorded on the customer service form and recorded in the PIHP complaint database for analysis. Action taken by the PIHP is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of complaints that may be made. The total number of calendar and working days from receipt to completion are also recorded. If the complainant is not satisfied with the initial resolution, the individual may request to appeal the decision. The quarterly complaint reporting form includes the aggregate information on complaints to include:
(1) The total number of complaints received by the customer service office
(2) The total number of persons (by category) who are reporting complaints
(3) The total number of consumers by age group
(4) The total number of consumers by disability group (if applicable) involved in the complaint
(5) The primary nature of the complaints/concerns (by category)

(6) A summary of data analyses to identify patterns, strategies developed to address problems and actions taken
(7) An evaluation of results of actions taken and recommendations for next steps.
As stated in Appendix F-2 above, grievances (complaints) are also reported to the state Medicaid agency on a quarterly basis as required by the risk contract between the DHHS Division of Medical Assistance and the PIHP. The Division of Medical Assistance and the DMH/DD/SAS have developed a joint reporting form to increase consistency of processes to the extent possible. The grievance process is conducted by the PIHP and is an expression of dissatisfaction by the enrollee about things
that are not "actions." Actions refers to denial of a service request; limited authorization of a service request; reduction, suspension, or termination of a previously authorized service; denial of payment for a service; failure to authorize or deny a service request in a timely manner; or failure to resolve a grievance (i.e., within 90 calendar days). The grievance process is separate from the
reconsideration/state fair hearing process. Enrollees do not have to file a grievance before requesting reconsideration of an action.
The appeal process (called "reconsideration" in North Carolina) is conducted by the PIHP. Appeal refers to a request for review of an action (please refer to the definition in the previous section of what constitutes "actions"). Appeals can be filed in writing or orally by the enrollee or provider (with written consent). The enrollee has 30 days to request an appeal of the PIHP action. If the request is made orally, the enrollee must submit a written request within 30 days of the date of the adverse notice. Individuals making decisions on appeals cannot have been involved in any previous level of review or decision-making. The enrollee must be allowed a reasonable opportunity
to present evidence and allegations of fact or law and must be allowed to examine his/her medical records and the documents considered during the appeal. For standard resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 45 days from the day the PIHP receives the appeal. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the PIHP receives the appeal. Timeframes to decide both grievances and appeals (both standard and expedited) may be extended up to fourteen (14) calendar days if additional information is required. In North Carolina, enrollees must exhaust the PIHP Appeal Process ("Reconsideration") before accessing the State Fair Hearing (referred to as an "Appeal"). Medicaid State Fair Hearings are governed by 42 Code of Federal Regulation (CFR) Part 431 and utilize the Administrative Hearings procedure. These hearings apply to an appeal ("reconsideration") not decided wholly in favor of the enrollee. The PIHP is a party to the State Fair Hearing and the process is controlled by state law and rules. The enrollee has 30 days to request a State Fair Hearing from the date of the appeal ("reconsideration") decision. After 30 days, the PIHP appeal ("reconsideration") decision becomes final.
Appe

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The DHHS Incident and Death Response System Guidelines describes who must report the documentation required, what/when/where reports must be filed and the levels of incidents, including responses to each level of incidents. Critical incident reporting requirements are outlined in North Carolina Administrative Code at 10A NCAC 27 G.0600. Providers of publicly funded services licensed under North Carolina General Statute 122C, with the

exception of hospitals, and providers of publicly funded non- licensed periodic or community based mental health, developmental disability or substance abuse services are required to report critical events or incidents involving consumers receiving mental health, developmental disability or substance abuse services. 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 HIPAA/confidentiality violations. Level I incident reports are reviewed by the employee's supervisor, and are submitted to a designated person, per agency policy. The PIHP also requires that Level 1 incidents for SED Waiver 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 DHHS Division of MH/DD/SAS.
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. 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 and to the PIHP. 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. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence. All providers required to conduct a peer review of Level III incidents, beginning within 24 hours of the incident.

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

At the time of enrollment in the PIHP, participants will be 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 Wraparound facilitator 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 SED 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. 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. Each provider agency 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 SED Waiver 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 is responsible for attending to the health and safety of involved parties as well as analyzing causes, correcting problems and review in quality improvement process to prevent similar incidents. Level II incidents may signal a need for the PIHP to review the provider's clinical care and practices and the PIHP's management processes, including service coordination, service oversight and technical assistance for providers. These incidents require communication between the provider and the PIHP, documentation of the incident and report to the PIHP and other authorities as required by law. The PIHP
is responsible for reviewing provider handling of the incident and ensuring consumer safety.
Level III Incidents are immediately reported to the PIHP who notifies DMH/DD/SAS. The PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared and reviewed by the agency or employer submitting the incident. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence. Providers 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 Disability Rights, formerly the Governor's Advocacy Council for Persons with Disabilities analyzes trends and advocates as warranted
A summary of incident reporting and follow-up actions is included in the PIHP'S reporting to DMA.
Providers are required to develop and implement written policies governing their response to incidents, including conducting investigations. The policies must also include attending to the health and safety needs of individuals involved in the incident, determining the cause of the incident, and developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days. Polices must also include notification of the participant of the results of any investigation. The timeframe for informing the participant, including all relevant parties, of the investigation results is within three (3) months of the date of the incident. The PIHP submits a summary of incident reports as well as related performance measures to DMA on a quarterly basis.
A provider internal review team must meet within 24 hours of any incident that results in,
or creates a significant risk of resulting in death, sexual assault or permanent physical or psychological impairment to a consumer or by a consumer. In North Carolina, these are referred to as Level III Incidents. The internal review team consists of individuals who were not involved in the incident and who were not responsible for the consumer's direct care or with the direct professional oversight of the consumer's services at the time of the

incident. Preliminary findings of fact are sent to the host PIHP and the PIHP where the consumer resides (if different) within five (5) working days of the incident. A final written report signed by the owner of the provider organization is submitted to the PIHP within three (3) months of the incident. The final written report must address the issues identified by the internal review team; include all public documents related to the incident, and make recommendations for minimizing the occurrence of future incidents. The provider must also immediately report incidents of this level to the host PIHP, the
PIHP where the consumer resides (if different), the North Carolina Department of Health and Human Services through the online Incident Response Improvement System (IRIS), the provider agency with responsibility for maintaining and updating the consumer's treatment plan if different from the reporting provider, the consumer'slegal guardian if applicable, and any other authorities required by law.
The PIHP must report Level III Incidents to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Licensed providers must also send a copy of all Level III Incidents involving a consumer death to the NC Division of Health Service Regulation within 72 hours of becoming aware of the incident.
All cases of client death must be reported immediately to the PIHP.
Each PIHP develops and implements written policies governing local monitoring based on provider incident reporting. Minimally, these policies include review of how providers respond to incidents and ensure consumer safety, monitor and provide technical
assistance as warranted to ensure that problems are corrected, analyze and respond to patterns of incidents as part of QI monitoring and processes, report aggregate information to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), determine if public scrutiny is an issue, and ensure that Level III Incidents are reported to the DMH/DD/SAS.
The DMH/DD/SAS is responsible for analyzing and responding to statewide patterns of incidents as part of QI and monitoring PIHP oversight of response processes, produce statewide quarterly incident trend reports, review PIHP oversight of providers and follow up as warranted to ensure problems are corrected, analyze and respond to statewide patterns of incidents as part of QI and monitoring processes, and produce statewide quarterly incident trend reports.

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

The Department of Health and Human Services is the State Department that oversees the Division of Medical Assistance (DMA) and the DMH/DD/SAS. DMA tracks performance measures and receives all incident reports quarterly. The DMH/DD/SAS also assists in the oversight of critical
incidents and events. The DMH/DD/SAS communicates this information through quarterly trend reports.
Aggregate data for all incidents is collected by the provider and submitted to the PIHP quarterly. The PIHP submits this data to DMA as well as DMH/DD/SAS quarterly. Additionally, all Level II and Level III incidents are recorded in the North Carolina online Incident Response Information System. DMA and the DMH/DD/SAS reviews all data and monitors the PIHPs oversight of providers and follows up as warranted to ensure that problems are corrected. The DMH/DD/SAS also analyzes and responds to statewide patterns of incidents as part of Quality Improvement and monitoring processes. The DMH/DD/SAS also produces quarterly trend reports that are made available to the DMA, DHHS and other interested parties.
Level I incidents are reported to the PIHP in aggregate form. The aggregate data is reviewed by the PIHP, DMA, and the DMH/DD/SAS quarterly. Level II and Level III incidents are reported by the provider within 72 hours of the incident occurring. The PIHP and the DMH/DD/SAS reviews all Level III incidents within 72 hours of receiving the report. In cases of consumer death within 7 days of restrictive intervention, the PIHP and the DHHS is notified immediately.
Appendix G:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

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

NC Administrative Code at 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.
Restrictive interventions are reported via the incident reporting rules at 10A NCAC 27 G.0600. The DHHS Restrictive Intervention Details Report is completed along with the incident report. Restrictive interventions governed by 10a NCAC 27e .0104 include seclusion, physical restraint and isolation time-out. Use of these interventions is limited to emergency situations in order to terminate a behavior or action in which the individual is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or as a planned measure of therapeutic treatment. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.
Positive and less restrictive alternatives must be considered and attempted whenever possible prior to the use of more restrictive interventions. Providers shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. They shall establish training based on state competencies and the contents of the training must be approved by DMH/DD/SAS. Formal refresher training must be completed by each service provider at least annually. Competencies include:
• knowledge and understanding of the people being served;
• recognizing and interpreting human behavior;
• recognizing the effect of internal and external stressors that may affect people with disabilities;
• strategies for building positive relationships with persons with disabilities;
• recognizing cultural, environmental and organizational factors that may affect people with disabilities;
• recognizing the importance of and assisting in the person's involvement in making decisions about their life;
• skills in assessing individual risk for escalating behavior;
• communication strategies for defusing and de-escalating potentially dangerous behavior; and
• positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
Emergency interventions may only be employed for up to 15 minutes without further authorization by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. Whenever an individual is in seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior, the individual must be observed at least every 15 minutes, or more often as necessary, to assure safety. Whenever an individual is in isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the individual. There shall be continuous observation and verbal interaction when appropriate. This observation must be documented. If an individual is in a physical restraint and may be subject to injury, a facility employee shall remain present with the individual continuously.
When protective devices are used for an individual, there must be documentation that the staff are trained and competent to use the device, that there has been a review of less restrictive alternatives that have not been successful, and that review has been made by a Client Right's Committee. The intervention and monitoring of the individual for health and safety must be documented.
When restraints are used, there must be continuous assessment of the individual to ensure their physical and psychological wellbeing throughout the intervention. Staff who are trained in emergency safety interventions and CPR must be present during the restrictive procedure.
Seclusion, physical restraint and isolation time-out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint and isolation time-out

and shall not use these interventions until the training is completed and competence is demonstrated. A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. The training shall be competency-based and must be approved by DMH/DD/SAS. A formal refresher training must be completed by each staff at least annually. Training programs shall include, but are not limited to, presentation of:
• refresher information on alternatives to the use of restrictive interventions;
• guidelines on when to intervene (understanding imminent danger to self and others);
• emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
• strategies for the safe implementation of restrictive interventions;
• the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
• prohibited procedures;
• debriefing strategies, including their importance and purpose; and
• documentation methods/procedures.
At a minimum documentation of the use of restraints or seclusion must include:
• the individual's physical and psychological well-being;
• frequency, intensity and duration of the behavior which led to the intervention
• any precipitating event;
• the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
• a description of the intervention and the date, time and duration of its use;
• a description of accompanying positive methods of intervention;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
• signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.
When any restrictive intervention is utilized, the legally responsible person shall be notified immediately unless she/he has requested not to be notified. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by a Human Rights Committee prior to implementation. Utilization of any restrictive procedure, planned or unplanned (unauthorized) will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the LME-PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP. Care Coordination monitors at least quarterly to ensure any restrictive interventions are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee.

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

State agencies and the PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs report quarterly on the use of restraints to DMA. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The PIHPs provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP.
Providers report aggregate data to the PIHP quarterly. The PIHP collects this data for DMA.

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Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

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

NC Administrative Code at 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.
Restrictive interventions are reported via the incident reporting rules at 10A NCAC 27 G.0600. The DHHS Restrictive Intervention Details Report is completed along with the incident report. Restrictive interventions governed by 10a NCAC 27e .0104 include seclusion, physical restraint and isolation time-out. Use of these interventions is limited to emergency situations in order to terminate a behavior or action in which the individual is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or as a planned measure of therapeutic treatment. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.
Positive and less restrictive alternatives must be considered and attempted whenever possible prior to the use of more restrictive interventions. Providers shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. They shall establish training based on state competencies and the contents of the training must be approved by DMH/DD/SAS. Formal refresher training must be completed by each service provider at least annually. Competencies include:
• knowledge and understanding of the people being served;
• recognizing and interpreting human behavior;
• recognizing the effect of internal and external stressors that may affect people with disabilities;
• strategies for building positive relationships with persons with disabilities;
• recognizing cultural, environmental and organizational factors that may affect people with disabilities;
• recognizing the importance of and assisting in the person's involvement in making decisions about their life;
• skills in assessing individual risk for escalating behavior;
• communication strategies for defusing and de-escalating potentially dangerous behavior; and
• positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
Emergency interventions may only be employed for up to 15 minutes without further authorization by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. Whenever an individual is in seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior, the individual must be observed at least every 15 minutes, or more often as necessary, to assure safety. Whenever an individual is in isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the individual. There shall be continuous observation and verbal interaction when appropriate. This observation must be documented. If an individual is in a physical restraint and may be subject to injury, a facility employee shall remain present with the individual continuously.

When protective devices are used for an individual, there must be documentation that the staff are trained and competent to use the device, that there has been a review of less restrictive alternatives that have not been successful, and that review has been made by a Client Right's Committee. The intervention and monitoring of the individual for health and safety must be documented.
When restraints are used, there must be continuous assessment of the individual to ensure their physical and psychological wellbeing throughout the intervention. Staff who are trained in emergency safety interventions and CPR must be present during the restrictive procedure.
Seclusion, physical restraint and isolation time-out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. The training shall be competency-based and must be approved by DMH/DD/SAS. A formal refresher training must be completed by each staff at least annually. Training programs shall include, but are not limited to, presentation of:
• refresher information on alternatives to the use of restrictive interventions;
• guidelines on when to intervene (understanding imminent danger to self and others);
• emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
• strategies for the safe implementation of restrictive interventions;
• the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
• prohibited procedures;
• debriefing strategies, including their importance and purpose; and
• documentation methods/procedures.
At a minimum documentation of the use of restraints or seclusion must include:
• the individual's physical and psychological well-being;
• frequency, intensity and duration of the behavior which led to the intervention
• any precipitating event;
• the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
• a description of the intervention and the date, time and duration of its use;
• a description of accompanying positive methods of intervention;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
• signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

When any restrictive intervention is utilized, the legally responsible person shall be notified immediately unless she/he has requested not to be notified. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by a Human Rights Committee prior to implementation. Utilization of any restrictive procedure, planned or unplanned (unauthorized) will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the LME-PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP. Care Coordination monitors at least quarterly to ensure any restrictive interventions are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee.

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

State agencies and the PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs report quarterly on the use of restraints to DMA. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information

System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries,emergency behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The PIHPs provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP.
If the agency is licensed through the Division of Health Service Regulation, the PIHP, DMA, or the DMH/DD/SAS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP quarterly. The PIHP collects this data for DMA.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

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

When any restrictive intervention is utilized, the legally responsible person shall be notified immediately unless she/he has requested not to be notified. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Utilization of any restrictive procedure, will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the LME-PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP. Care Coordination monitors at least quarterly to ensure any restrictive interventions are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee.

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

State agencies and the PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs report quarterly on the use of restraints to DMA. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries,emergency behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The PIHPs provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy

and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP.
If the agency is licensed through the Division of Health Service Regulation, the PIHP, DMA, or the DMH/DD/SAS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP quarterly. The PIHP collects this data for DMA.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

The single licensed setting in which a waiver participant will be residing is a Licensed Foster Home or a licensed Therapeutic Foster Home. In North Carolina, 10A NCAC 70G .0510 MEDICATION ADMINISTRATION REQUIREMENTS regulates the administration of medication in Foster Care Homes through the Child Placing Agency.
(a) The agency shall have written policies and procedures regarding foster parents administering medications to children placed in their home that shall be discussed with each child and the child's parents, guardian or legal custodian, prior to or upon placement.
(b) These policies and procedures shall address medication:
(1) administration;
(2) dispensing, packaging, labeling, storage and disposal;
(3) review;
(4) education and training; and
(5) documentation, including medication orders, Medication Administration Record (MAR), orders and copies of lab tests, and medication administration errors and adverse drug reactions.
(c) Upon discharge of a child from foster care, the foster parents or the agency shall return prescription medication to the person or agency legally authorized to remove the child from foster care. Unwanted, out-dated, improperly labeled, damaged, adulterated or discontinued prescription medications shall be returned to a pharmacy for disposal.
(d) The agency shall ensure that each child started or maintained on a medication by a licensed medical provider receives either oral or written education regarding the prescribed medication by the licensed medical provider or his or her designee. In instances where the ability of the child to understand the education is questionable, the agency shall ensure that a responsible person receives either oral or written education regarding the prescribed medication by the licensed medical provider or his or her designee and provides either oral or written instructions to the child. The agency shall ensure that the medication education provided is sufficient to enable the child or other responsible person to make an informed consent, to safely administer the medication and to encourage compliance with the prescribed regimen. The CPA will monitor the foster home's compliance with the following requirements.
When a child is in a licensed Foster Home, Foster parents are responsible for the following regarding medication:
(1) General requirements:
(a) retain the manufacturer's label with expiration dates visible on non-prescription drug containers not dispensed by a pharmacist;
(b) administer prescription drugs to a child only on the written order of a person authorized by law to prescribe drugs;
(c) allow prescription medications to be self-administered by children only when authorized in writing by the

child's licensed medical provider;
(d) allow non-prescription medications to be administered to a child taking prescription medications only when authorized by the child's licensed medical provider; allow non-prescription medications to be administered to a child not taking prescription medication, with the authorization of the parents, guardian, legal custodian, or licensed medical provider;
(e) allow injections to be administered by unlicensed persons who have been trained by a registered nurse, pharmacist, or other person allowed by law to train unlicensed persons to administer injections;
(f) record in a Medication Administration Record (MAR) provided by the supervising agency all drugs administered to each child. The MAR shall include the following: child's name; name, strength, and quantity of the drug; instructions for administering the drug; date and time the drug is administered, discontinued, or returned to the supervising agency or the person legally authorized to remove the child from foster care; name or initials of person administering or returning the drug; child requests for changes or clarifications concerning medications; and child's refusal of any drug; and
(g) follow-up for child requests for changes or clarifications concerning medications with an appointment or consultation with a licensed medical provider.
(2) Medication disposal:
(a) return prescription medications to the supervising agency or person legally authorized to remove the child from foster care; and
(b) return discontinued prescription medications to a pharmacy or the supervising agency for disposal, in accordance with 10A NCAC 70G .0510(c).
(3) Medication storage:
(a) store prescription and over-the-counter medications in a locked cabinet in a clean, well-lighted, well-ventilated room other than bathrooms, kitchen, or utility room between 59° F (15° C) and 86° F (30° C);
(b) store medications in a refrigerator, if required, between 36° F (2° C) and 46° F (8° C). If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container within the refrigerator; and
(c) store prescription medications separately for each child.
(4) Psychotropic medication review:
(a) arrange for any child receiving psychotropic medications to have his/her drug regimen reviewed by the child's licensed medical provider at least every six months;
(b) report the findings of the drug regimen review to the supervising agency; and
(c) document the drug review in the MAR along with any prescribed changes.
(5) Medication errors:
(a) report drug administration errors or adverse drug reactions to a licensed medical provider or pharmacist; and
(b) document the drug administered and the drug reaction in the MAR.

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.

There will be multiple methods of oversight of this medication management. First the Child Placing agency will monitor the foster homes to assure that the home is following the policy and procedures for administering the medication. Additionally, The state's DSS office monitors the Child Placing Agencies at least every two years to include a site visit to the agency, file reviews, and a review of administrative items, which may include Medicaid Administration.

The Wraparound facilitator will be informed of the medications the participant is on and assure that there are regular Medication Management appointments with the prescribing doctor. The Wraparound Facilitator will also work with the Parent Trainer or the Parent Partner to make sure that the child's family or caregiver are aware of the medications, their side effects and expected benefits. If concerns are raised or dissatisfaction on the part of the family or youth about a child's medication, the Wrap Facilitator, parent partner or parent training will assist getting the concerns addressed with the provider.

Additionally at the state level, in North Carolina, when a Medicaid eligible child is prescribed an antipsychotic medication, the prescriber must report this prescription to the state's Fiscal Agent for authorization, with justification, for approval. The prescribing patterns can be monitored and reviewed.
Providers will be required to complete an A+KIDS prior authorization (PA) for any preferred or non-preferred antipsychotic medication and an ASAP authorization for any non-FDA approved use and any non-preferred antipsychotic for all Medicaid beneficiaries. Providers will be required to complete this prior authorization through the NCTracks Provider Portal or by via telephone. A+KIDS –The program encourages the use of

appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in Medicaid beneficiaries under the age of 18. Providers will once again be required to document information regarding the efficacy of therapy, side effects, and metabolic monitoring parameters (height/weight/BMI
percentile, lipid panel, and blood glucose). Once the information is submitted to the NCTRACKS web-based portal or phoned in successfully, the medication is authorized for 6 months.
The ASAP program targets off-label prescribing of antipsychotic agents and atypical (second generation) antipsychotic agents prescribed for an indication that is not approved by the federal Food and Drug Administration.
To authorize the prior authorization for approved indications, the prescriber must write in his or her own handwriting "meets PA criteria" on the face of each new or renewal antipsychotic prescription or in the comment block on e-prescriptions. The authorization period is equivalent to the length of the prescription.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Only when a child is receiving Out of Home Respite in a Therapeutic Foster Home, will a waiver provider be responsible for administering medication.

Foster parents are responsible for the following regarding medication:
(1) General requirements:
(a) retain the manufacturer's label with expiration dates visible on non-prescription drug containers not dispensed by a pharmacist;
(b) administer prescription drugs to a child only on the written order of a person authorized by law to prescribe drugs;
(c) allow prescription medications to be self-administered by children only when authorized in writing by the child's licensed medical provider;
(d) allow non-prescription medications to be administered to a child taking prescription medications only when authorized by the child's licensed medical provider; allow non-prescription medications to be administered to a child not taking prescription medication, with the authorization of the parents, guardian, legal custodian, or licensed medical provider;
(e) allow injections to be administered by unlicensed persons who have been trained by a registered nurse, pharmacist, or other person allowed by law to train unlicensed persons to administer injections;
(f) record in a Medication Administration Record (MAR) provided by the supervising agency all drugs administered to each child. The MAR shall include the following: child's name; name, strength, and quantity of the drug; instructions for administering the drug; date and time the drug is administered, discontinued, or returned to the supervising agency or the person legally authorized to remove the child from foster care; name or initials of person administering or returning the drug; child requests for changes or clarifications concerning medications; and child's refusal of any drug; and
(g) follow-up for child requests for changes or clarifications concerning medications with an appointment or consultation with a licensed medical provider.
(2) Medication disposal:
(a) return prescription medications to the supervising agency or person legally authorized to remove the child from foster care; and
(b) return discontinued prescription medications to a pharmacy or the supervising agency for disposal, in

accordance with 10A NCAC 70G .0510(c).
(3) Medication storage:
(a) store prescription and over-the-counter medications in a locked cabinet in a clean, well-lighted, well-ventilated room other than bathrooms, kitchen, or utility room between 59° F (15° C) and 86° F (30° C);
(b) store medications in a refrigerator, if required, between 36° F (2° C) and 46° F (8° C). If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container within the refrigerator; and
(c) store prescription medications separately for each child.
(4) Psychotropic medication review:
(a) arrange for any child receiving psychotropic medications to have his/her drug regimen reviewed by the child's licensed medical provider at least every six months;
(b) report the findings of the drug regimen review to the supervising agency; and
(c) document the drug review in the MAR along with any prescribed changes.
(5) Medication errors:
(a) report drug administration errors or adverse drug reactions to a licensed medical provider or pharmacist; and
(b) document the drug administered and the drug reaction in the MAR.

iii. **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

The Department of Health and Human Services, Division of Social Services, Regulatory and Licensure Section.

(b) Specify the types of medication errors that providers are required to *record:*

All Medication Errors must be recorded on the Medication Administration Report, which is subject to review by the Child Placing Agency.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication Errors that result in hospitalization must be reported to the State's Division of Social Services.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Both the Division of Social Services and the PIHP, under contract with DMA will be responsible for monitoring the performance of waiver providers in the administration of Medication.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and Percent of actions taken to protect the individual, where indicated. Numerator: Number of actions taken to protect the individual from additional harm, where indicated. Denominator: All actions where protective actions were indicated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

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	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Percentage of level 2 and 3 incidents reported within required timeframes. Numerator: Number of incidents addressed within required timeframes as specified in State Policy. Denominator: Total number of incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incident reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: PIHP	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of restrictive interventions resulting in medical treatment. Numerator: Number of individuals requiring emergency medical treatment or hospitalization due to injury related to the use of a restrictive intervention. Denominator: All individuals who have had a restrictive intervention.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incident reports NC Incident Reporting System

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

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DMH/DD/SAS	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
The percentage of individuals under the age of 21 who had a primary care or preventative care visit during the waiver year. Numerator: Number of individuals on the waiver under the age of 21 who had a primary care or preventative care visit during the waiver year. Denominator: Number of individuals on the waiver

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of claims data on primary care or preventative care visits

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The PIHPs will analyze and address problems identified and include the analysis in the report to DMA and the Intra-Departmental monitoring team. In situations where providers are involved, the PIHPs may require provider corrective action plans or take other measures to ensure consumer protection. DMA will require corrective action plans or take other measures to ensure consumer protection. DMA will require corrective action plans of the PIHP if it is determined that appropriate action was not taken by the PIHP. Such corrective action plans are subject to DMA approval and monitored by DMA. DMA requires the PIHPs to contact DMA immediately about any issue that has or may have a significant negative impact on an individual's health and welfare. DMA and the PIHPs work together to resolve such issues as they occur.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The North Carolina quality management strategy for the waiver is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes. The strategy focuses on methods for coordinating, assessing and continually improving the delivery of behavioral healthcare provided through prepaid inpatient health plans (PIHPs). The strategy encompasses an interdisciplinary collaborative approach through partnerships with enrollees and their families, stakeholders, governmental departments and divisions, contractors, the PIHPs, and community groups. System improvements are made based on findings from a number of discovery activities, including: performance measures and the DMA-PIHP contracts; ongoing performance improvement projects; onsite reviews by Intra-Departmental Monitoring Teams (IMT); external quality reviews; grievances and appeals tracking and trending; network adequacy studies; and consumer and provider surveys. (A brief description of each key activity and how they are used for system improvement is provided at the end of this narrative.)

Findings from these activities are reviewed and addressed at three levels. First, each PIHP operating under the (b)(c) waivers has a contract manager from DMA's Behavioral Health Section who monitors the PIHP on a day-to-day basis, provides technical assistance, and collects and analyzes data from the discovery activities. Any issues needing immediate remediation are handled at this level.

The second level is an Intra-Departmental monitoring team (IMT) assigned to each PIHP. Each IMT is led by DMA and consists of the DMA contract manager and other staff from the State Medicaid Agency, the Division of MH/DD/SAS, other divisions within the NC DHHS as needed and the PIHP. Collectively, the individuals staffing the IMT have expertise in all areas of waiver operations, including clinical, finance, health

information systems, program integrity, quality management and state and federal rules and regulations

relevant to the waiver program. The IMTs meet quarterly. The role of the IMTs is to monitor the operations of their respective PIHPs, provide technical assistance, review findings from discovery activities, identify challenges and successes, make recommendations for system improvements and monitor progress of any corrective action plans.

A third level of review and feedback is conducted by the DHHS Waiver Advisory Committee (DWAC). The DWAC is comprised of staff from DHHS, DMA, DMHDDSAS, the PIHPs, and representatives from provider and consumer groups, including local community and family advisory committees (CFAC), provider associations and local provider network councils. The DWAC reviews quarterly and annual report summaries of PIHP performance. The DWAC provides consultation around local and statewide system goals; reviews outcome measures and trend data; highlights and recommends areas of best practice; and assists with problem identification and resolution. DWAC members are expected to communicate issues, concerns, and feedback from their constituent groups.

Through this multi-level process which provides for evaluation and feedback from consumers, providers, state staff and program experts, both challenges and successes in operating the waivers are identified. Potential solutions to concerns are thoroughly vetted by all stakeholders through the IMT and DWAC, and recommendations are made to DMA for system improvements.

Discovery Activities:
Performance Measures and Performance Improvement Projects:
The performance measure results will be reviewed annually and benchmarked with established performance standards/goals. DMA has also identified performance improvement projects that address a range of priority issues for the Medicaid population. Each PIHP is required to implement performance improvement projects in both clinical and non-clinical areas and report findings to DMA.

On-Site Reviews:
DMA and DMH conduct onsite monitoring reviews of each PIHP annually to evaluate compliance with the terms of the contract between DMA and the PIHP and State and federal Medicaid requirements. The review of administrative operations (financial management, information technology, claims) and clinical operations (care management, utilization management, network management, quality management) consists of a documentation review and onsite interviews. A review of MH/DD/SAS care management records may be included in the review. Any compliance issues found during the review will
require the submission of a corrective action plan to the IMT for approval and ongoing monitoring.

External Quality Review:
The federal and State regulatory requirements and performance standards as they apply to PIHPs are evaluated

annually for the State in accordance with 42 CFR 438.310 by an independent External Quality Review Organization (EQRO), including a review of the services covered under each PIHP contract for a) timeliness, b) outcomes and c) accessibility. The EQRO produces, at least, the following information:
• A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness and access to care furnished by the PIHP.
• Validation of performance measures and performance improvement projects
• Recommendations for improving the quality of healthcare services furnished by the PIHP
• An assessment of the degree to which the PIHP effectively addressed previous EQRO review recommendations
EQR results and technical reports are reviewed by the IMT for feedback. Ongoing EQR status reports, and final technical and project reports, are communicated through the IMT. Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements, performance measures or performance improvement projects. Report results are also used to determine levels of compliance with requirements and assist in identifying next steps.

Grievance and Appeal Reports:
DMA review of grievance and appeal information is used to assess quality and utilization of care and services.

The PIHP reports address type of grievance, source of grievance, type of provider (MH, I/DD, SA) and grievance resolution. The number, types and disposition of appeals are also reported. Results from ongoing analysis are applied to evaluation of grievances with quality expectations. Reports are submitted to DMA quarterly.

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Network Adequacy:
The PIHPs are required to establish and maintain provider networks that meet the service needs of the waiver participants and to establish policies and procedures to monitor the adequacy, accessibility and availability of their provider networks. The PIHPs are required to conduct an analysis of their networks to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members

to practitioners and facilities. The analysis and findings are submitted to DMA annually.

Provider and Consumer Surveys:
DMA administers a consumer survey annually designed to measure adult and child consumer experience and satisfaction with the PIHP. The survey contains questions designed to measure at least the following dimensions of client satisfaction with PIHP providers, services, delivery and quality:
– Overall satisfaction with PIHP services, delivery, access to care and quality
– Consumer knowledge of managed care from a patient's perspective
– Consumer knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process
– Cultural sensitivity
– Consumer perception of accessibility to services, including access to providers
– Additional factors that may be requested by the State

DMA also administers a provider survey annually. The purpose of the provider satisfaction survey is to solicit input from providers regarding levels of satisfaction with program areas, such as claims submission and

payment, assistance from the PIHP and communication.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The need for system design changes is identified through the Intra-Departmental monitoring teams (IMT) and DHHS Waiver Advisory Committee (DWAC) which make recommendations to DMA. DMA prioritizes and implements the needed changes. Contract managers, the IMTs and the DWAC use the discovery activities described above on an ongoing basis to determine whether the desired improvements have been achieved. Additional discovery activities or changes to those already in place may be made to more effectively track the result of system changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality strategy is reviewed by the quality staff of 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 and revised based upon analysis of results by the quality management staff in DMA and the 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. If changes need to be made to the quality strategy, DMA seeks public input.

The revised quality management strategy is placed on the DMA website for public input over a 30-day period. In addition, each PIHP will present the quality strategy update for comments at CQI and CFAC meetings. Once
public input has been received, the final strategy document is prepared and approved by the quality management staff in DMA. Following approval by DMA, any amendments to the quality strategy are shared with CMS. The final quality strategy is also published on the DMA website.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Division of Medical Assistance (DMA) makes a capitated payment monthly to the
PIHPs for each enrollee and the PIHPs provide all needed MH/DD/SA services to Medicaid recipients through their provider networks. The PIHPs are required through their contracts with DMA 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 PIHPs must report any incidents of fraud and abuse to DMA. Provider agencies are monitored at a frequency set by the PIHPs but no less than every three years.

The PIHPs are also contractually required to have their annual financial reports audited in accordance with generally accepted auditing standards by an independent certified public accountant and submit the audits to 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 and as needed 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The PIHP has the authority to require corrective action plans of each of their providers and recoup payments if they find that services are provided inappropriately – i.e., services are not provided in accordance with program requirements. The 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 reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the PIHP.

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

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

Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State employs an actuary to calculate actuarially sound payment rates per 42 CFR 438.6(c).
The PIHPs are responsible for setting all provider rates for waiver services. The PIHPs set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. The PIHPs use the State's Medicaid rates for the same or similar services as a guide in setting rates.
All proposed changes to existing rates or for implementing new rates are reviewed internally by the PIHPs and externally by their respective PIHP provider advisory committee. The provider council is comprised of a cross section of the PIHP's provider networks. Rate reviews focus on internal and external equity and consistency. Providers are notified of rate changes by announcement at the provider meetings and online posting on the PIHP's website.
The PIHPs reimburse waiver service providers on a fee-for-service basis for most services and for most providers. To the extent that providers are capitated, then service level encounter data is provided so that the State can track services and set PIHP capitated rates.
For services provided through the individual and family directed option (employer of record model), the administrative portion of the service rate is set aside to cover charges for other administrative costs. The direct service portion of the rate is made available to the employer of record for wages and benefits.

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:

DMA makes capitated payments to the PIHPs monthly for each waiver participant through the State's Medicaid Management Information System (MMIS), in accordance with Section A.I.B of the concurrent 1915(b) waiver, "Delivery Systems" and the risk contract between the state Medicaid agency and the PIHP. The capitated payments are considered payment in full for all services covered under the waiver program.
Individual providers bill the PIHPs according to the terms of their respective contracts with the PIHP. The contract between DMA and the PIHPs outline requirements for subcontracting and timeliness of payment to providers by the PIHP. The PIHP may not contract with a subcontractor who is not eligible for participation in the Medicaid program.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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c. **Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

At the state level:
The State determines eligibility for capitated payments by identifying individuals through the Medicaid Management Information System (MMIS) who, as of a set date at the end of each month have a special indicator that signifies participation in the SED Waiver. (The special indicator is entered in the State's Eligibility Information System (EIS) by the local departments of social services upon notification by the PIHPs that the individual has been approved for waiver participation. Eligibility changes are transmitted to the MMIS on a nightly basis.) The MMIS generates a capitated payment to the PIHPs at the beginning of the following month for each waiver participant identified through this process. DMA requires the PIHPs 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 SED waiver participation is determined by the PIHPs and eligibility for Medicaid is determined by the local
departments of social services (DSS). Initial level of care determinations are made by the PIHPs. The PIHPs notify the DSS when eligibility for waiver participation is authorized, the DSS then enters the special waiver indicator into the State's Eligibility Information System and the indicator is transmitted to the MMIS. The MMIS generates an enrollment report at the end of each month, which identifies waiver participants for whom payment will be made at the beginning of the next month. The PIHPs use this report to verify that waiver eligibility has been entered into the system and to identify any waiver participants who have lost Medicaid eligibility. Regarding payment for waiver services according to the plan of care, authorization for the individual waiver services in the plan is entered into the

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PIHP's claims payment system, which prevents payment for unauthorized services. The PIHPs 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 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

  The PIHPs notify the local department of social services (DSS) that the individual has been approved to participate in the waiver. The DSS then enters eligibility for waiver participation into the State's Eligibility Information System (EIS). 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; or, the DSS, 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.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid**

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program.

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Not Applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

The PIHPs retain 100 percent of the monthly capitated payment.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct**

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payments to a governmental agency.

◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

◉ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

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☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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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) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

In the rate setting process for each service, the cost of Room and Board is not included. The services reflect the cost of delivering the waiver services exclusive of any room and board expenses.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	24386.00	20121.00	44507.00	37806.00	15705.00	53511.00	9004.00
2	24381.65	20121.00	44502.65	37806.00	15705.00	53511.00	9008.35
3	24384.99	20121.00	44505.99	37806.00	15705.00	53511.00	9005.01

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

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:
		Hospital
Year 1	180	180
Year 2	228	228

Year 3	324	324

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Since this is a new waiver, the average length of stay was based on a review of the average lengths of stay in other 1915c waivers for children with SED. These lengths of stay ranged from 163 up to 365. The length of stay of 270 was approximate to 268 days or the mid point between the shortest and longest average lengths of stay. The average of nine states representing both PRTF Demonstration waivers as well as states with SED 1915c Waiver utilizing hospital expenditures for psychiatric inpatient and hospital PRTF services was 250 days. As a new waiver, the 270 day average length of stay was also based on clinical judgement regarding the time required for children and families to participate in waiver services in order to make sufficient progress towards their goals and to reduce the likelihood of regression to pre treatment emotional and behavioral functioning levels. This length of stay may be adjusted following experience in North Carolina and analysis of North Carolina's data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

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:

Estimated utilization of waiver services for one recipient is based on analysis of utilization data and cost data gathered from PRTF Demonstration Sites and on data from SED Waivers in other states such as Michigan that developed a waiver based on State Hospital level of care for children and youth.

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:

Factor D' estimates are based on the data analysis reported the following report that found that for children and youth using the most intensive behavioral health services, their average costs for physical health services were $20121 annually. S. Pires, K. Grimes, T. Gilmer, K. Allen, R. Mahadevan. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies. December 2013.

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:

Mercer's Data Summary of 2014 Medicaid Expenditures for PRTF services located in licensed hospitals.

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:

Mercer's Data Summary of 2014 Medicaid Expenditures for medical inpatient, outpatient, pharmacy and professional services for children and youth with SED who used psychiatric acute inpatient or hospital PRTF level of care.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

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Waiver Services
In Home Respite
Out of Home Respite
Wraparound Facilitation
Assistive Technology
Community Transition
Home and Community Living Skills
Individual Goods and Services/Flex Funds
Parent Peer Support
Parent Training and Counseling
Specialized Consultation
Youth Peer Support

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Respite Total:							220970.88
In Home Respite	☑	15 minutes	117	416.00	4.54	220970.88	
Out of Home Respite Total:							58320.00
Out of Home Respite	☑	day	27	12.00	180.00	58320.00	
Wraparound Facilitation Total:							2090880.00
Wraparound Facilitation	☑	month	180	12.00	968.00	2090880.00	
Assistive Technology Total:							2000.00
Assistive Technology	☑	1	4	1.00	500.00	2000.00	
Community Transition Total:							6000.00
Community Transition	☑	1	4	1.00	1500.00	6000.00	
Home and Community Living Skills Total:							451951.20
Home and Community Living Skills	☑	15 minutes	72	410.00	15.31	451951.20	
Individual Goods and Services/Flex Funds Total:							86400.00

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Individual Goods and Services/Flex Funds	☑	Event	72	1.00	1200.00	86400.00	
Parent Peer Support Total:							881856.00
Parent Peer Support	☑	15 minutes	120	480.00	15.31	881856.00	
Parent Training and Counseling Total:							299520.00
Parent Training and Counseling	☑	15 minutes	72	208.00	20.00	299520.00	
Specialized Consultation Total:							201268.80
Specialized Consultation	☑	15 minutes	72	90.00	31.06	201268.80	
Youth Peer Support Total:							90357.12
Youth Peer Support	☑	15 minutes	36	216.00	11.62	90357.12	

GRAND TOTAL:		4389524.00
Total: Services included in capitation:		4389524.00
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		180
Factor D (Divide total by number of participants):		24386.00
Services included in capitation:		24386.00
Services not included in capitation:		
Average Length of Stay on the Waiver:	270	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In Home Respite Total:							273977.60
In Home Respite	☐	15 minutes	148	416.00	4.45	273977.60	
Out of Home Respite Total:							73440.00
Out of Home Respite	☐	day	34	12.00	180.00	73440.00	
Wraparound Facilitation Total:							2648448.00
Wraparound Facilitation	☐	month	228				