



NC Innovations
INDIVIDUAL
and **FAMILY**
Guide



BKT988150E00



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Member and Recipient Services: 800-510-9132

This handbook is available in Spanish and in alternate formats. If you need a larger-print version, or have limited reading ability, call Alliance Health at 800-510-9132.

The current edition of this handbook is available on the Alliance website at AllianceHealthPlan.org.

Si necesita información en español, llámenos al 800-510-9132.

Alliance Health serves the counties of Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake in North Carolina



A Message from Rob Robinson Chief Executive Officer

Welcome to NC Innovations. This guide is designed to provide information about the NC Innovations Waiver that will help you better understand the services and supports that can be funded through the NC Innovations Home and Community Based Waiver. Alliance Health is committed to working with the North Carolina Department of Health and Human Services to provide services “one person at a time” in a manner that meets your life goals.

We will notify you if the information in this guide changes. If you have questions at any time or would like additional information about NC Innovations, please contact your Alliance Care Manager or any of the other Alliance staff listed in this guide and posted on our website at AllianceHealthPlan.org. If you do not have access to a computer, your Care Team or any Alliance staff person can assist you.

I also want to let you know that we are dedicated to quality services and have high standards for our providers and ourselves. Our network of providers is committed to quality, and we trust that you will experience this in the services you receive. However, if you do not receive quality services or if you ever receive less than excellent customer service, we want to hear from you. You may call **Alliance Member and Recipient Services toll-free at 800-510-9132** and you will have the option to remain anonymous. We will investigate and help resolve your concern. Additionally, your feedback will help us make improvements. Also, let us know when you are especially pleased, as this helps us learn what consumers like about our system and about specific providers.

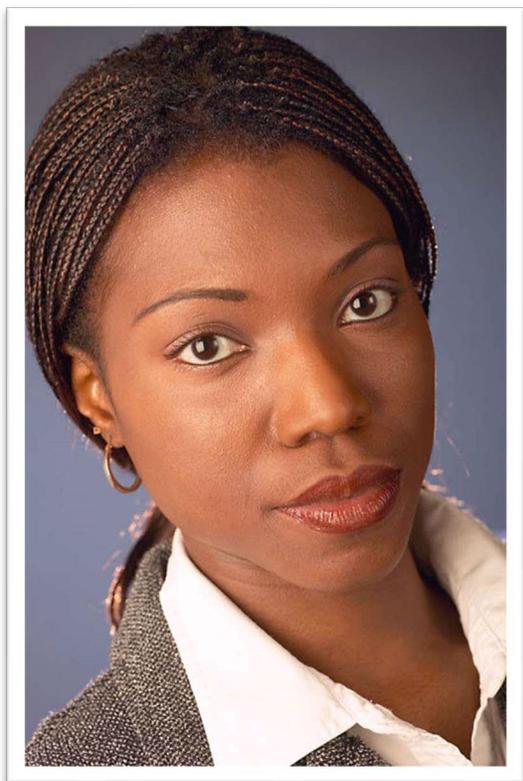
The Alliance system is a successful system of care for people seeking services that are publicly funded. We strongly encourage our providers to use best practice methods that are proven to produce positive changes in people’s lives. The strengths, preferences, and support needs of the person receiving services is at the center of all that we do. We call this person-centered planning and it is all about the priorities of the person receiving services and their self-identified family members.

Whatever your goals are in seeking services, we wish you the best and we are here to support you in your efforts!

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Section 1:
**Introduction to Medicaid
Home and Community-Based
Services (HCBS) Waivers and
NC Innovations Waiver**

**NC Innovations is a Medicaid Home
and Community-Based Waiver (HCBS)**

This section of the guide provides an explanation of:

- Purpose and Goals of NC Innovations**
- Required Basic Service Elements**
- Base Budget and Non-Base Budget**

Medicaid Home and Community-Based Services (HCBS) Waivers

Medicaid is a federal program originally designed to provide medical care and institutional services for people. It has many rules that control how services are delivered. “Waivers” allow a state to have some of the Medicaid rules “waived” so that there is more choice about how and where services are provided.

NC Innovations

The North Carolina Innovations Waiver is a means of funding services and supports for people with intellectual or other related developmental disabilities that are at risk for institutional care in an intermediate care facility for Individuals with Intellectual Disabilities (ICF-IID). NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. This waiver, approved to be effective July 1, 2019 for five years, operates concurrently with a 1915 (b) Waiver, the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan). The NC MH/DD/SAS Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and developmental disabilities services are authorized for Medicaid participants.

Local Management Entities/Managed Care Organizations (LME/MCOs) are area authorities in North Carolina responsible for certain management and oversight activities with respect to publicly funded MH/DD/SAS services and are PIHPs for the waiver.

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

The NC Division of Health Benefits (DHB), the state Medicaid agency, operates the NC Innovations Waiver. DHB contracts with the LME/MCO (Prepaid Inpatient Health Plan) to arrange for and manage the delivery of services, and perform other waiver operational functions under the concurrent 1915 (b)/(c) waivers. DHB directly oversees the NC Innovations Waiver, approves all policies and procedures governing waiver operations and ensures that the NC Innovations Waiver assurances are met.

What Medicaid Rules are “Waived” for NC Innovations?

Statewideness

The Social Security Act requires Medicaid services to be provided on a statewide basis. This requirement is waived to limit NC Innovations Waiver participants to legal residents (for the

purpose of Medicaid eligibility) of the PIHP region. Alliance manages the PIHP for residents of Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.

Comparable Services

The Social Security Act requires a state to provide comparable services in amount, duration and scope to all Medicaid recipients. This requirement is waived to allow NC Innovations Waiver services to be offered only to individuals participating in the NC Innovations Waiver.

Deeming of Income and Resources

Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This is "deeming" income and resources to the Medicaid recipient. The deeming requirement is waived to allow Medicaid eligibility for individuals participating in the NC Innovations Waiver to be considered similar to the methods used for people who are residing in ICF-IID group homes or the state developmental centers.

Purpose and Goals of NC Innovations

The NC Innovations Waiver is designed to provide an array of community-based services and supports to promote choice, control and community integration that are medically necessary to assure health and safety. They provide a community-based alternative to institutional care for persons who require ICF-IID level of care and meet additional eligibility criteria for this waiver.

The Goals of the NC Innovations Waiver are:

- To value and support waiver participants to be fully functioning members of their community.
- To promote promising practices that result in real life outcomes for participants.
- To offer service options that will facilitate each participant's ability to live in homes of their choice, have employment or engage in purposeful day activities of their choice, and to achieve their life goals.
- To provide the opportunity for all participants to direct their services to the extent that they choose.
- To provide educational opportunities and support to foster the development of stronger natural support networks and enable participants to be less reliant on formal support systems.
- To maximize beneficiaries' self-determination, self-advocacy and self-sufficiency.
- To increase opportunities for community integration through work, life-long learning, recreation and socialization.
- To deliver person-centered services that leverage natural and community supports.
- To provide quality services and improve outcomes.

Provider Directed vs. Individual and Family Directed Supports (Agency with Choice and Employer of Record Options)

When developing your person-centered Individual Support Plan (ISP) and choosing your services, you have the opportunity to choose how you want to manage your services. You can choose to manage your services in one of three ways:

1. Selecting a provider agency to deliver your services. This is known as **Provider-Directed Services**.

There are two options for self-directed care:

2. Working with an agency that agrees to hire employees referred by you. This is known as the **Individual and Family-Directed Services – Agency with Choice** option. The Agency with Choice retains responsibility for being the employer while allowing you to partner in managing the employee's training and supervision.
3. Or, working with a financial supports services agency and a Community Navigator, you have the ability to recruit, hire, train or arrange for training, schedule work, evaluate and even terminate the direct service employees. This is known as the **Individual and Family-Directed Services – Employer of Record** option. You, as the employer of record, fulfill all requirements for managing direct care staff and completing required documentation and the financial support services agency is responsible for billing, paying salaries, and assuring that funds outlined in the ISP are managed and distributed as intended.

Your Care Manager can provide more information to help you decide which of these options is best for you. A Community Navigator can provide you with training should you want to learn more about NC Innovations Self Direction options and the requirements involved.

You can access the Alliance Individual and Family Directed Supports Handbook at www.alliancehealthplan.org/document-library/72957.

Required Basic Service Elements for NC Innovations

The following elements are required to participate in the NC Innovations Waiver.

Alliance Care Teams

Your services will be managed by a team of Alliance staff who are qualified professionals offering care management through a multi-disciplinary team approach.

Care Managers employed by Alliance Health are Qualified Professionals (QPs) in North Carolina's credentialing system with competencies in person-centered planning. Care Managers and NC Innovations participants stay in contact as frequently as necessary, especially as needs change. Innovations participants are responsible for immediately notifying their Care Manager of any emergency situation or other circumstance that could affect their life and require a change in the person-centered ISP. Please also notify your Care Manager of any changes in your

address or contact information. Each member receiving services will also have a Care Worker that will monitor the services received.

Care Managers

- Serve as the main point of contact for the member.
- Communicate updates and submit referrals to other Care Team members.
- Identify and document needs for services and supports.
- Develop the person-centered ISP with long-range outcomes in collaboration with the individual, their family, and others of their choice
- Assure that short-range goals are developed by the provider agency in accordance with the annual plan.
- Complete the individual budget form.
- Identify choices and coordinate services.
- Offer information on self-directed options.

Care Workers

- Enhance the member's experience with network providers to achieve identified treatment and recovery goals.
- Monitor the delivery of services to the member, and assessing member satisfaction and engagement.

Community Health Workers

- Help address unmet social service needs (housing, food, utility payments, employment, and community inclusion).
- Connect members to community resources to meet identified needs.
- Assist with coordination of member payers, resolve Medicaid enrollment issues, and support NC SOAR (SSI/SSDI Outreach, Access and Recovery) activities if applicable.

Integrated Health Consultant

- A member of the Alliance Medical team who reviews physical health needs and consults with community physical health providers if needed.
- May also suggest equipment or technology that would promote positive health outcomes for the member.

Person-Centered Planning: Individual Support Plan (ISP)

The ISP is developed through a person-centered planning process and is led by the participant and/or legally responsible person to the extent they desire. Person-centered planning focuses on supporting participants to realize their own vision for their lives. It is a process of building effective and collaborative partnerships with participants and working with them to create a road map to reach their goals. A well-written person-centered plan is a rich, meaningful tool that describes the participant's strengths, preferences, goals and needs for support. It generates actions – positive steps the participant and service provider will take towards realizing the goals that are most important in the person-centered plan. Members can choose a plan template to use from the approved options.

The planning process begins with an assessment of the appropriateness of the participant’s current services/living arrangement based on what is important *to* and what is important *for* the participant. The Care Manager assists the participant in scheduling the meeting and inviting team members to the meeting at a time and location of the participant’s preference. Each team member receives a written invitation to the meeting. The participant and the Care Manager review with the team all issues that were identified during the assessment process. 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 the frequency for monitoring the participant’s services, supports and health/safety issues. During the planning meeting, decisions are made regarding team member responsibilities for service implementation and monitoring. While the Care Manager is responsible for overall monitoring of the ISP and the participant’s situation, the Care Worker and other team members, including the participant and family and other members of the community who support the participant, may be assigned monitoring responsibilities.

The clinical assessment tool used to measure individual support needs is the Supports Intensity Scale (SIS)[™]. The SIS[™] is a well-rounded tool for determining the level of supports an individual needs in daily living, as well as behavioral and medical needs. There are also additional questions asked about community safety risks, extreme self-injury risk, or extraordinary medical care needs. The tool provides a guidance in the ISP (annual plan) development and is to be used during the planning process. Again, the SIS[™] is a guideline that does not set a limit that may be requested or authorized in a plan of care.

Base Budget Services and Non-Base Budget Services

Everyone receiving NC Innovations funding receives an individual budget tool. This tool is a guideline that typically reflects the amount of base budget services needed to support the individual. “Non-base budget services” are generally preventative, equipment or support services that are available based on individual need.

The individual budget cannot total more than the Innovations Waiver cost limit of \$135,000 per year.

<p>NC Innovations Waiver Base Budget Services</p>	<ul style="list-style-type: none">• Community Networking Service• Day Supports• Community Living and Supports• Respite• Supported Employment
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<p style="text-align: center;">NC Innovations Waiver Non-Base Budget Services (Not Funded by the Base Budget)</p>	<ul style="list-style-type: none"> • Assistive Technology, Equipment and Supplies • Community Navigator • Community Transition • Crisis Services • Financial Support Services • Individual Goods and Services • Home Modifications • Natural Supports Education • Specialized Consultation Services • Vehicle Modifications • Residential Supports • Supported Living*
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Participants can request services and supports that exceed the base budget. The Care Manager will assist with making that request.

*Effective May 1, 2020, the Centers for Medicare and Medicaid Services approved a technical amendment to the NC Innovations waiver which allows exception to the \$135,000 per waiver year limit. NC Innovations beneficiaries may exceed \$135,000 Waiver Cost Limit to ensure health, safety and wellbeing, if the following criteria is met:

- The individual lives independently without his or her family in a home that s/he owns, rents or leases, and
- The individual receives Supported Living Level III, and
- The individual requires 24-hour support.

Individuals requesting services and supports in excess of the \$135,000 cost limit must make this request through the Individual Support Plan or Plan Update process. Services and Supports that exceed the \$135,000 must be prior approved by Alliance Health and must be related to the beneficiary's needs and not for the convenience of the provider agency or caregiver.

Individual Budget Tool

The Individual Budget Tool (IBT) as mentioned earlier is a guideline that typically reflects the amount of base budget services needed to support the individual. The IBT looks at the following information:

- Living arrangement – Those receiving residential/supported living services and individuals NOT receiving residential/supported living services
- Age of the individual – Individuals under age 22 are considered a child and individuals 22 and over are considered an adult. A person under the age of 22 moves from the child to the adult category when they graduate with a high school diploma, complete their GED, or occupational course of study.
- The Supports Intensity Scale (SIS)TM assessment that assesses level of need. This assessment is addressed further in Section 2.

Based on the person's living arrangement and age they will fall within four categories:

- Non-residential child (under 22 years old who have not completed high school and living in a private home).
- Residential/supported living child (under 22 years old who has not completed high school and living in a group home, an alternative family living (AFL) setting or a supported living setting).
- Non-residential adult (age 22 and over, or under the age of 22 with documentation of completion of high school, and living in a private home).
- Residential/supported living adult (age 22 and over, or under the age of 22 with documentation of completion of high school, and living in a group home, an AFL or supported living setting).

Within each of these four categories, there are seven levels of support based on the individuals' levels of need reflected in their SIS™ assessment. The seven levels are clinical descriptions that represent groupings of individuals who have similar support needs. ADL support references the amount of support the person needs for activities of daily living such as dressing, bathing, work, leisure, and homemaking.

The Seven Levels of Support

Level A: Minimal ADL support needs.

Level B: Moderate ADL support needs.

Level C: Minimal/moderate ADL supports needs with behavioral support overlay.

Level D: Moderate/high ADL supports needs.

Level E: High ADL support needs.

Level F: Some ADL support needs with extraordinary medical support overlay.

Level G: Some ADL support needs with extraordinary behavioral support overlay.

The Human Services Research Institute (HSRI) assigns an individual budget guideline using the Individual Budget Tool. How does this happen?

- The LME/MCO conducts the Supports Intensity Scale (SIS)™ for members enrolled in the Innovations Waiver.
- The LME/MCO gives HSRI the SIS™ scores.
- HSRI looks at the individual's age, SIS™ scores, and living arrangement to generate a support level and an IBT (base budget guideline).
- Alliance then accesses the individual budgets/levels and generates letters informing people enrolled on the Innovations waiver of their IBT.

The individual base budget is a guideline! All services covered under the Innovations waiver, including residential supports and supported living, should be requested based on the individual's needs, regardless of the individual's IBT/budgeting guideline.

The most recent SIS™ assessment information will be utilized in reviewing all service requests. A new SIS™ assessment can be requested by the member or family at any time there is a substantial life change, or the accuracy of the SIS™ is questioned.

Documentation and Waiver Limitations

Documentation is required to access and use NC Innovations services. Alliance is required to assure that NC Innovations funds are used appropriately and comply with all federal and state regulations. Federal Medicaid requires that there be adequate documentation by the provider to support the type of service, level of service (individual or group) and amount of service (hours)

that are received. Federal Medicaid expects that the services people receive directly match their documented needs.

NC Innovations waiver funds cannot be used for services and supports for adults that are approved for the NC TBI waiver.

There are also limits on some services and groups of services (see Appendix B for additional information about service limitations).

Quality Assurance and Improvement

Alliance and the state and federal government monitor the use of waiver funding to make sure that participants are satisfied with the services and support they receive. Alliance, the state and the federal government also want to make sure those services are helping people make progress with the goals and outcomes listed in their Individual Support Plans (ISP).

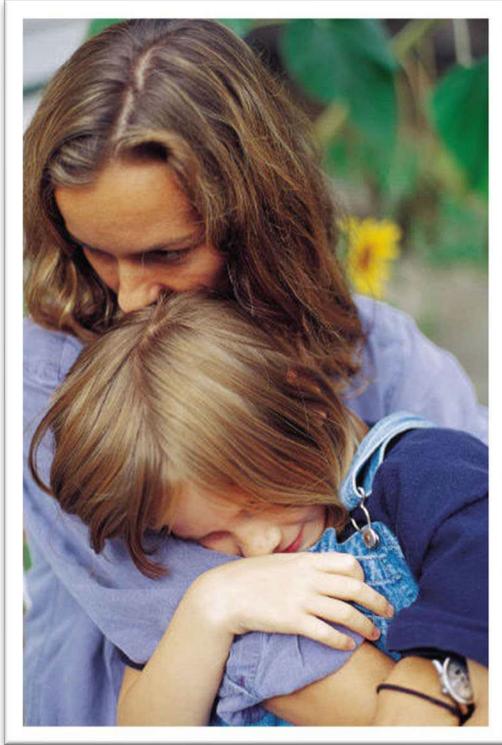
Waiver participants, their family, and/or guardians, will be asked to participate in the following quality processes:

- Care worker or care manager monitoring visits to your home and to other places you receive services.
- Consumer satisfaction surveys.
- Reviews of the services you receive by the Alliance Quality Management Department.

Re-Enrollment in NC Innovations

NC Innovations operates on a waiver year that runs from July 1-June 30. If you leave NC Innovations, during the waiver year, you can re-enter the waiver if you re-enter before the current waiver year ends, provided that you continue to meet the requirements of the waiver.

If you leave NC Innovations and return after the current waiver year has ended, you may be unable to enter the waiver right away. If funding is not available, you will be placed on the Registry of Unmet Needs, also known as the Innovations waitlist.



Section 2: How to Access and Receive NC Innovations Waiver Services

This section of the guide provides an explanation of:

Applying for NC Innovations Funding

NC Innovations Eligibility

Level of Care Assessment

Supports Intensity Scale (SIS)[™] Risk Assessment

Prioritization and Registry of Unmet Needs

Applying for NC Innovations Funding

A person must first be screened and determined eligible by Alliance in order to receive services and/or to be placed on the Registry of Unmet Needs for NC Innovations funding. Screening and eligibility determination is started by calling:

Alliance Health
Member and Recipient Services
800-510-9132

When you call this number, you will be directed to a qualified I/DD care manager who will work with you to gather the necessary documentation and information to determine potential eligibility for the NC Innovations waiver. *A copy of the most recent standardized testing by a licensed professional (psychologist, licensed psychological associate or physician) is needed in order to establish potential eligibility.* The I/DD care manager will help gather documentation and/or make a referral to the network provider of choice for additional evaluation as needed and connect you to other services/supports that may be available while waiting for the waiver.

Who is Eligible for NC Innovations?

NC Innovations services are covered for a Medicaid beneficiary with intellectual or developmental disabilities, or both, who meets **ALL** of the following criteria:

- Requires ICF-IID level of care,
- Resides in an ICF-IID facility or is at high risk of being placed in an ICF-IID facility.
- Able to maintain his or her health, safety and well-being in the community with NC Innovations services,
- Requires NC Innovations services as identified through a person-centered planning process,
- Requires at least one regularly scheduled NC Innovation service provided monthly (does not include respite care), and
- Alone or with his or her family or legal guardian, a person chooses to participate in NC Innovations rather than live in an institution.

What is ICF-IID Level of Care?

In order to meet ICF-IID (intermediate care facility) level of care a person must:

- Require active treatment in accordance with 42 CFR 483.440. Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally independent persons who are able to function with little supervision or in the absence of a continuous active treatment program, **AND**

- Have a diagnosis of intellectual disability (ID) per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition,

OR a condition closely related to intellectual disability defined as follows:

- Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, practical and social skills. The intellectual disability must occur before the age of 18.
- Closely related conditions refers to individuals who have severe, chronic disability that meets **ALL** of the following conditions:
 - Is attributable to cerebral palsy, or epilepsy that occurred before the age of 22, **OR**
 - Any condition, other than mental illness found to be closely related to intellectual disability because the condition results in impairment of general functioning or adaptive behavior similar to a person with intellectual disability.
- Is manifested before the person reaches the age of 22.
- Is likely to continue indefinitely.

AND results in substantial functional limitations in three or more of the following areas of life activity:

- Self-care.
- Understanding/use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

How Is ICF-IID Eligibility/Level of Care Determined?

- If you apply for NC Innovations Waiver funding, your level of care assessment is completed by a psychologist/ psychological associate in our network or your physician (MD or DO) based on your disability. Alliance will make the arrangements for your evaluation, obtain historical assessment information or will send these professionals a form to complete.
 - If your disability is intellectual disability or a disability related to intellectual disability, a psychologist/psychological associate will complete your assessment. An adaptive behavior assessment and IQ (intelligence quotient) test will be completed, or if you have a current evaluation, the assessment will be reviewed and an update completed if needed.
- If the condition is cerebral palsy, epilepsy or a condition closely related to one of these two disabilities, documentation from a physician would be accepted.
- Once the psychologist, psychological associate or physician has established eligibility, the Alliance I/DD Utilization Management department authorizes care. Each year your level of

care is assessed by your Care Manager and a determination is made by Utilization Management about your continued eligibility for the level of care required for participation in NC Innovations.

Supports Intensity Scale (SIS)[™]

Once your assessment has indicated that you are eligible for participation in NC Innovations, Alliance will arrange for your support needs to be evaluated using the Supports Intensity Scale (SIS)[™]. The SIS[™] is an important tool to assist you and your planning team in identifying services and supports that meet your needs, including issues with physical limitations and/or medical needs. The SIS[™] assessment is required for everyone on the Innovations waiver.

The SIS includes an interview by a trained SIS[™] assessor with you and the people of your choosing who know you well that focuses on your need for support. These people are called “respondents” and can be neighbors, friends or providers who are very familiar with your skills and abilities and who have known you for at least three months. The SIS[™] interviewer may also review your records to obtain additional information needed to complete the SIS[™].

The SIS[™] is completed at a minimum of every two years for children and three years for adults while you are on the NC Innovations Waiver. If you have any questions or concerns about the results of your SIS[™] evaluation, you may contact your Care Manager. It is possible for results to be adjusted if you do not feel that your support needs were fully captured by the evaluation. You may also file a grievance if you do not agree with your SIS[™] results. Filing a grievance does not prevent you from advocating that your SIS[™] results are incorrect during an appeal.

Components of the SIS[™]

The SIS[™] is an assessment tool to measure the supports an individual needs to live a meaningful life in the community. It is used to inform supports planning and resource allocation. People are asked questions about their specific level of need for support in several areas.

- **Section 1 of the SIS[™]** asks about the individual’s support needs for home living, community living, lifelong learning, employment, health and safety and social activities.
- **Section 2 of the SIS[™]** asks about the individual’s support needs for speaking up for him/herself and others (advocacy), managing money, making choices and staying safe.
- **Section 3 of the SIS[™]** asks about the individual’s support needs for medical and behavioral challenges.

There are four SIS[™] supplemental questions that assist with identify individuals with the highest level of medical and/or behavioral support needs. These questions deal with:

- Severe medical risk.
- Severe community safety risk (convicted).
- Severe community safety risk (not convicted).
- Severe risk of injury to self.

Risk/Support Needs Assessment

A risk/support needs assessment is completed by your Care Manager. This assessment captures potential risks and safety considerations that can include health, medical and/or behavioral areas of concern. It also lets you inform your team of the allied supports you receive such as medical specialists, physical/ occupational/ speech therapists, or psychologist and the frequency of those supports. Your Care Manager makes sure these risks/needs are addressed in your person-centered ISP and as needed, in a crisis plan.

Prioritization and Registry of Unmet Needs

If funding is not available for needed Innovations services at the time of enrollment with Alliance and the individual is determined potentially eligible for the NC Innovations Waiver, the person is placed on the Registry of Unmet Needs for their county of residence until funding is available. Individuals are prioritized for funding based on the date and time of their referral to the NC Innovations Waiver. People with emergency needs are offered emergency reserved capacity funding, if available. If funding is not available, alternative resources will be identified to ensure health and safety. Money Follows the Person (MFP) reserved capacity funding may be available to those who continue to meet ICF level of care and wish to leave community or developmental center ICF-IIDs or Psychiatric Residential Treatment Facilities (PRTF) and return to their community using Innovations-funded services. When NC Innovations funding is available, funding is assigned geographically based on Medicaid per capita population in each of the counties where NC Innovations is operating. It is important that you keep Alliance and your local Department of Social Services (DSS) notified of any address changes as you will be notified via U.S. mail when funding becomes available.

Freedom of Choice

If you choose to apply for NC Innovations services, this means that you are choosing these services rather than placement in an ICF-IID institutional facility. You will review and sign the “Freedom of Choice Statement” annually. As a NC Innovations Waiver participant, you are free to choose between ICF-IID Institutional services and NC Innovations waiver services.

Participant Responsibilities

Your Care Manager will assist you in reviewing and signing the participant responsibilities form annually. This form outlines the responsibilities of each NC Innovations Waiver participant and important waiver policies that the person needs to be aware of before they agree to participate in the waiver. Your Care Manager will discuss the form with you when you enter the waiver and each year you continue to receive waiver services (see Appendix A).

Applying for Medicaid

Medicaid eligibility is a separate process from eligibility for NC Innovations. A person can be eligible for Medicaid health insurance and not be eligible for NC Innovations. Your county Department of Social Services (DSS) is the local expert in Medicaid eligibility. If you receive Supplemental Security Income (SSI), you automatically receive Medicaid in North Carolina. Everyone who receives NC Innovations services must be determined eligible for Medicaid by the Department of Social Services (DSS) in the county in which they live. Only people whose Medicaid is from Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties can participate in the NC Innovations Waiver managed by Alliance.

Cumberland County Department of Social Services
1225 Ramsey Street
PO Box 2429 Fayetteville, NC
910-323-1540

Durham County Department of Social Services
414 E. Main Street
PO Box 810 Durham, NC
919-560-8000

Harnett County Department of Social Services
311 Cornelius Harnett Boulevard
Lillington, NC
910-893-7500

Johnston County Department of Social Services
714 North Street
PO Box 911, Smithfield, NC
919-989-5300

Wake County Department of Social Services
220 Swinburne Street
PO Box 46833 Raleigh, NC
919-212-7000

Mecklenburg County Department of Social Services

DSS Main office:	West Charlotte Location:
Wallace H. Kuralt Centre	Community Resource Center
301 Billingsley Road	3205 Freedom Drive
Charlotte, NC	Charlotte, NC

Orange County Department of Social Services
Hillsborough Commons
113 Mayo Street
Hillsborough, NC

Things to Know About Medicaid

- Everyone receiving NC Innovations has Medicaid, but not everyone on Medicaid participates in NC Innovations.
- If needed, an Alliance Care Manager will assist you in completing a Medicaid application. If you already have Medicaid, the Alliance staff person can assist you in contacting DSS to let them know that you are applying for NC Innovations.
- It is important that you provide DSS with all of the information they need to process or update your Medicaid application and that you read and respond to all letters they send you.
- When an individual applies for SSI (Social Security Income), the application is also an application for Medicaid. Individuals apply for SSI at their local Social Security Administration office.
- It is important that you keep your Care Manager informed of any address change or change with SSI payments as these changes can affect Medicaid eligibility and as a result, disrupt your NC Innovations services.
- It is important that you keep DSS informed of any changes in your place of residence. If you plan to move to a county outside Alliance's catchment area, please notify your DSS Medicaid case worker and Care Manager right away so they can assist with transferring to avoid a lapse in services. Innovations waiver services and funding does transfer within the state of North Carolina from LME/MCO to LME/MCO based on Medicaid county.

Medicaid Deductibles

A Medicaid deductible (also referred to as a "spend down") is similar to a private insurance deductible. A deductible applies only when the individual's income exceeds a set limit. It is the amount of medical expenses for which the individual is responsible before Medicaid will pay for covered services.

- Unlike private insurance, the Medicaid deductible is based on income, and therefore the amount is not the same for each person.
- DSS will tell you if you have a deductible. If you receive an inheritance or a large sum of money, contact DSS and your Care Manager immediately to talk about the possibility of deductible changes.
- Medicaid will not pay for services while an individual is in deductible status.
- For NC Innovations Waiver participants, the deductible is calculated over a six-month time period, and is divided into six monthly payment amounts.
- NC Innovations funding cannot pay for services anytime Medicaid is not in effect due to a deductible.

Meeting Your Medicaid Deductible

If you have a Medicaid deductible, your Care Manager can help you plan to meet your deductible each month. You will not receive Medicaid coverage for Innovations services until you meet your Medicaid deductible. A Medicaid deductible is met by adding up medical costs.

Payments for medical care, supplies, prescriptions and services may apply to your deductible. You will be authorized for Medicaid on the date that the bills add up to the amount of the deductible. Copies of bills that are used to meet the deductible must be received by DSS before DSS can issue your Medicaid coverage.

Some individuals meet their deductible by purchasing their medications at the beginning of the month. Others choose to be billed and pay for the first days of their NC Innovations services from a provider agency. If you choose this option, you should remember that you are expected to pay the provider agency for the services you receive before your Medicaid coverage begins. If you do not pay the bill for these services, the provider agency may choose to discontinue your services

Co-Payments

Some Medicaid coverage or those with multiple insurance policies such as Medicaid and Medicare Part D requires a co-payment by the Medicaid participant. Visits to physicians, dentists and optometrists, as well as prescriptions, are examples of services that may require a co-payment.

- If you receive Medicare and do not have prescription drug coverage, you should ask your Care Manager for information about Medicare prescription drug coverage.
- As a NC Innovations participant, you are also exempt from the eight-prescription limit per month, unless you also receive Medicare.
- If a provider agency or pharmacy is not aware of the exemption, you should suggest that the agency contact Alliance or refer to the Medicaid Pharmacy Clinical Coverage Policy.

If you have questions regarding your co-payments, please contact DSS.

Private Health Insurance (including Medicare)

Federal regulations require Medicaid to be the “payer of last resort.” This means that all third party insurance carriers, including Medicare and private health insurance carriers must pay before Medicaid pays. If the Medicaid payment for a service is more than the third party insurance carrier will cover, then Medicaid will pay the difference up to the Medicaid payment amount. If the insurance payment is more than the Medicaid payment amount, Medicaid will not pay any additional amount.

Medicaid denies payments for participants who are eligible for Medicare but who have not applied for Medicare.

If the provider’s service would have been covered and payable by the Medicare and/or private plan, but some requirement of the plan was not met, Medicaid will not pay for the service. **You must keep DSS, Medicaid, your Care Manager and your provider agency informed of any private insurance or Medicare coverage that you have.** If you do not inform these individuals/ agencies of your private insurance or if you do not cooperate in any way in meeting any private plan requirement, you may be responsible for paying for the service. This includes services covered by NC Innovations.



Section 3: Completing Your Person-Centered Individual Support Plan and Choosing the Services that are Right for You

This section of the guide provides an explanation of:

**The Individual Support Planning Process
Using Resources and Choosing Waiver Services
NC Innovations Service Definitions**

Completing the Person-Centered Individual Support Plan (ISP)

After you have applied for NC Innovations, completed the assessments, met the eligibility requirements, received an available slot, and been approved for Medicaid, your Care Manager will:

- Gather and organize information for you and your planning team.
- Ask you, your family, and the legally responsible person, if applicable, who you want included in your planning team and what part you want to take in leading the planning meeting.
- Document the results of your planning meeting including development of your ISP.
- Explain the different services to you and work with you to develop your plan based on the services desired.

Your ISP should:

- Have enough detail that someone new in your life can understand your needs.
- Identify any natural, unpaid and community supports that help meet your needs.
- Reflect the type, duration, and amount of service you desire.
- Clearly document **medical necessity** for the services you need (medically necessary treatment is explained on page 40).
- Include a schedule of when you need support and the kinds of support you need at different times of day.
- Assist others involved in your life in understanding your goals, preferences, and needs for support.
- Help identify and address risks that are present.
- Reflect the decisions you make.
- Be respectful of you and those who support you.
- Be easy to read using simple everyday language.
- Assist people who support you to find information easily.
- Identify how required emergency back-up services will be furnished when there are support staff absences or vacancies.

Using Resources and Choosing Waiver Services

Natural/Unpaid/Community Supports

When developing your ISP remember that NC Innovations is not intended to replace or duplicate services and resources that are already available to you. For example, if you have been visiting your grandmother one evening a month while your parents attend a meeting, you

would not need to receive a service instead of your visit with your grandmother. Natural supports are an important part of everyone's life and waiver services are not intended to replace them.

The next pages in this will provide you with information about NC Innovations Services so that you can work with your team to choose the ones that will best meet your needs.

NC Innovations Services are intended for you to continue living in and participating as an active member of your home community. It is important to understand that there are a variety of special limitations and restrictions on services. It is important that you discuss each service you need to use with your Care Manager. You may request services that you want to request, in the amount and for the length of time you want to request them. You have due process rights as an Innovations Waiver participant to appeal any denial or reduction of service requested. Please refer to page 43 regarding to the denial and appeal process.

Limitations and Regulations

The total of your base and "add on" services cannot exceed the waiver cost limit of \$135,000 per year.

If another Medicaid or other available service will meet your needs instead of a NC Innovations service, the other service must be used. Service payment cannot be made for a participant who is a patient of a hospital, nursing facility, or ICF-IID facility or a person who is incarcerated in a correctional facility.

Provider Responsibilities

- The need for services cannot be determined based on the need for a provider or employee to receive a particular reimbursement rate.
- Providers may not charge you or a member of your family any additional payment for services and/or equipment that have been billed to Medicaid. This applies to all NC Innovations services and equipment, and regular Medicaid services and equipment.
- You or your family cannot pay part of the cost of the service or equipment, or for home and vehicle modifications.
- Providers cannot ask you to sign an agreement that says you will not change provider agencies as a condition of providing services to you.

Individual vs. Group Services

For services that have a group option, the expectation is that the participant receives group services unless there is justification in the participant's ISP that individual services are necessary to meet the disability specific needs of the participant. In locations such as day programs or after-school programs, you will usually receive group services. If individual services are approved, it is expected that you and your team will continue to assess if some or all hours of service can be changed to group as you become more independent. Your planning team will submit information in your ISP and other documents such as medical documentation or behavior support plan to reflect the need for individual services. Individualized supports in a

facility based setting, such as day supports, should be supported with detailed documentation of the person's needs. Circumstances supporting individual services include behavioral or psychiatric destabilization, medical concerns/necessity, or other infrequent and exceptional circumstances. Individual day supports related to medical/behavioral/physical support needs shall require supporting medical or behavioral records and accompanying documentation in the ISP supporting the need for individual services as the most appropriate option.

Services for School Age (3-21) NC Innovations Participants

Federal regulations prohibit NC Innovations services from being used as a replacement for educational services funded under the Individuals with Disabilities Education Act (IDEA).

The following policy applies to school-aged individuals ages 3-21:

- NC Innovations services are offered outside of school operational hours, and are defined as the documented hours of the school system for the grade the child would attend.
- Respite may be utilized during school hours for sickness, injury, or when a student is suspended or expelled but does not include transportation to/from school settings.
- The family of children who are home schooled must present a copy of the home school certificate and schedule to the Care Manager. If the family does not provide the home school certificate and schedule, then the local school system schedule will apply. The home school schedule should closely match the child's base school schedule. Innovations waiver services cannot be utilized in place of services available to a child under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973. The schedule in the Individual Education Plan for homebound children will apply.
- Students **can** receive NC Innovations services outside their documented school, home school, or homebound school schedule.
- Educational outcomes cannot be funded by NC Innovations.
- Service and maintenance contracts/extended warranties; and equipment or supplies purchased for the exclusive use at the school/home school are not covered.
- The school system is responsible for transportation to and from the school setting and Innovations funding cannot be utilized for this purpose.
- Individuals ages 3-21 who reside in the home can receive up to 54 hours/week of services while school is in session and up to 84 hours/week when school is not in session.
- Individuals ages 3-21 who receive Residential Supports shall receive no more than 20 hours per week of allowable scheduled services when school is in session and up to 40 hours per week when school is not in session.
- 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:
 - 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
 - Furnished as a part of expanded habilitation services. Please see the limits on sets of services in Appendix B.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is Medicaid's Comprehensive Child Health Program for individuals under 21. EPSDT is authorized under the Medicaid Act and includes preventative services and screening of children, including vision, dental, and hearing services. The Act requires that any medically necessary health care service that is listed in the Act be provided to an EPSDT beneficiary even if the Medicaid State Plan does not cover those services. Your Care Manager can provide you with additional information about EPSDT.

EPSDT Criteria

- The service must be within the scope of those listed in the Social Security Act (42 U.S.C. 1396d (a)). For the purposes of the Innovations waiver, this means that community guide, community networking, community transition, crisis services, financial supports, day supports, residential supports, supported employment, home modification, in-home intensive support, in-home skill building, some individual goods and services, respite, specialized consultation services, and vehicle modifications are not covered under EPSDT.
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition diagnosed by the child's physician, therapist, or other licensed practitioner.
- The requested service must be a medical service.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental or investigational. This generally means that clinical trials are not covered under EPSDT.

For more information on EPSDT, call Member and Recipient Services at 800-510-9132 or talk to your healthcare provider.

Equipment and Supplies

If you need equipment or supplies you should contact your Care Manager for assistance. It is important to remember that NC Innovations funds cannot pay for equipment or supplies that are covered by your private health insurance, Medicare, or the Medicaid State Plan. Please contact your insurance or your Care Manager before purchasing equipment since private insurance companies, Medicare, and Medicaid have specific approval processes, providers, and service limitations that must be followed.

Your Care Manager can assist you in requesting equipment and supplies from NC Innovations under assistive technology equipment and supplies, your insurance provider, Medicare or from the Division of Health Benefits. If a request is denied, your Care Manager or Community Navigator will assist you in finding other funding sources for the equipment and supplies you need. Because obtaining the evaluations and other information needed for approval takes time, you should let your Care Manager know your needs as soon as possible so that the needed items can be added to your ISP and the supporting documentation obtained.

Assistive technology and supply requests require approval from Alliance Utilization Management. Once approval is obtained, Alliance will order equipment and/or supplies.

NC Innovations cannot pay for any item obtained prior to approval by Alliance Utilization Management. Assistive technology, equipment and supplies (ATES), and home modifications are limited to a combined total of \$ 50,000 over the life of the waiver.

If you need an item not covered by your private insurance, Medicaid, NC Innovations funding or EPSDT, your Care Manager can refer you to a Community Navigator to assist you in locating other possible funding sources such as private foundations, churches, civic organizations, and/or other community resources.

Steps for Obtaining Equipment and Supplies

1. Discuss your needs with your Care Manager and planning team.
2. Through your team, identify the specialist who needs to further assess your equipment needs.
3. Participate in the assessment.
4. Work with your Care Manager to obtain a statement of medical necessity from your physician for the specific equipment or supply recommended.
5. Work with your Care Manager to determine the potential source for funding the equipment or supply.
6. Work with your Care Manager to submit the request and required documentation for your insurance company, Medicare, Medicaid or NC Innovations.
7. Participate in training to learn to use your new equipment or supply.
8. Keep in close contact with your Care Manager and work with them to obtain any additional information requested from the funding source of your supply or equipment that is consistent with the NC Innovations service definitions.

Location of Services

In general, NC Innovations-funded services are provided at locations that best meet your Individual needs. However, some services must be provided at a specific location or under a specific type of license. Refer to the service definition in NC DHB Clinical Coverage Policy 8P for specific information about any limitation on where a service can be provided.

If you determine that there is a unique reason for you to receive services in the home of a direct service employee, the provider agency is required to complete a health and safety checklist/ justification form. You will be asked to sign this checklist.

The only services that can be provided in the home of a direct service employee are community living and supports and respite services. Sometimes your direct service employee's home must be licensed for you to receive respite services there.

Services in Residential Facilities

- If you receive NC Innovations funded services and live in a licensed facility, you may only live in a residential facility that serves four or fewer residents.
- NC Innovations services are not provided in ICF-IID residential facilities.
- Residential facilities must be licensed by the residential supports provider unless they are serving only one adult as unlicensed Alternative Family Living (AFL).
- All residential facilities for children must be licensed.

Qualifications of Staff Providing NC Innovations Waiver Services

The NC Innovations waiver and NC DHB Clinical Coverage Policy 8P identify provider qualifications for each NC Innovations Service. For all services, direct service employees must be at least 18 years of age and have at least a high school diploma or equivalency.

Service Definitions

NC Innovations service definitions, including limitations and provider requirements, are included in the waiver and in NC DHB Clinical Coverage Policy 8P. Links to these documents are posted on the Alliance website at AllianceHealthPlan.org. The information included here is an overview of each NC Innovations service and whether it is a “base” or “non-base budget” service. This section does not include the full service definitions and does not replace the policy.

Your Care Manager can also provide additional information about any service you have questions about. If you are self-directing your services, your community navigator can provide a copy of service definition(s) for the services you are self-directing.

All services require prior approval and may require additional documentation and/or assessments. Your Care Manager will assist you with this process.

Assistive Technology Equipment and Supplies (non-base budget)

Assistive technology equipment and supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain or improve functional capabilities of participants. This service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation.

The ISP clearly indicates a plan for training the participant, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant. A separate physician’s signature certifying medical necessity shall be included with the written request for assistive technology equipment and supplies when another professional (PhD, occupational therapist, physical therapist, speech therapist) completes the letter of medical necessity either in a separate letter or a sign off on the letter of medical necessity

prepared by the professional and a written prescription. When the physician, physician assistant, nurse practitioner, or Doctor of Osteopathic Medicine write the letter of medical necessity, a separate prescription is not needed. Equipment cannot be purchased prior to the item be approved.

Assistive technology equipment and supplies can be used for the cost of monthly monitoring. Monitoring systems using video, web cameras, or other technology are available on an individual basis but only with the full consent of the individual and his/her guardian as indicated in the individual's plan of care. It can be used for adaptive computer desks and other adaptive furniture only and cannot be used for non-adaptive furniture. Assistive technology equipment and supplies may be accessed for individual receiving residential supports when the item belongs to the individual and can transition to other settings with the individual. Items utilized as restraints are not covered under the waiver.

Assistive technology equipment and supplies and home modifications are limited to a combined total of \$50,000 over the life of the waiver.

Community Navigator (non-base budget)

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

These services also support individuals, representatives, and managing employers by providing assistance to those that direct their own waiver services. Community navigator is mandatory for all employers of record until competence in directing service is demonstrated. Community navigator services may be intermittent and will fade as community connections develop and skills increase in individual direction. Community navigators assist and support (rather than direct and manage) the individual throughout the service delivery process. Community navigator services are intended to enhance, not replace, existing natural and community resources. If the individual requires paid supports to participate/engage once connected with the activity, community networking is the appropriate service to utilize to refer and link the individual.

Community Networking: Service (base budget service); Class and Conference (non-base budget service, base budget service)

Community networking services provide individualized day activities that support the participant's definition of a meaningful day in an integrated community setting, with persons who are not disabled. This service is provided separate and apart from the participant's private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the participant the opportunity to develop meaningful community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. Community networking services enable the

participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community.

The ultimate purpose of NC Innovations services is to help individuals learn to become more independent and less reliant on services, therefore ongoing assessments of learning and skill acquisition are essential in determining ongoing service need. As participants gain skills and increase community connections, as determined by the consumer, family members, and providers, service hours may fade. However, a formal fading plan is not required.

This service pays for the staff support required to allow maximum participation in the community but does not cover non-integrated camps or childcare fees. The service does cover classes the individual may want to take that offer integration in the community with peers without disabilities.

Community Networking also includes integrated, community-based employment focused skill development including career exploration, discovery and career planning, participation in workshops and classes on topics related to integrated employment, skill and education-focused activities, volunteering opportunities, social networking and skills for socialization to obtain or maintain community based integrated employment.

Community Transition (non-base budget)

Community transition provides initial set-up expenses for adults to facilitate their transition from a developmental center (institution), community ICF-IID group home, nursing facility or another licensed living arrangement (group home, foster home, psychiatric residential treatment facility, alternative family living arrangement), or a family home/one person AFL (alternative family living), to a living arrangement where the individual is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the participant/legal guardian/representative's name or a home owned by the participant.

Pre-transition care coordination/care management and planning is included. Community transition does not include monthly rental/mortgage expenses; regular utility charges; and or household appliances or diversional/recreational/entertainment items such as televisions, computers, tablets, etc. This service is only available once over the life of the waiver with a limit over the life of the waiver of \$5000 per individual.

Crisis Services (non-base budget)

Crisis supports provide intervention and stabilization for individuals experiencing a crisis. Crisis supports are for individuals who experience acute crises and who present a threat to the person's health and safety or the health and safety of others. These behaviors may result in the person losing his or her home, job, or access to activities and community involvement. Crisis supports promote prevention of crises as well as assistance in stabilizing the individual when a behavioral crisis occurs.

Crisis services are an immediate intervention available 24 hours per day, 7 days per week to support the person who is primarily responsible for the care of the participant. Crisis services are provided as an attempt to prevent the need for institutional placement or psychiatric hospitalization. Service authorization can be accessed by telephone at the time the Crisis service is needed or can be planned through the ISP to meet the needs of the participant.

Following service authorization, any needed modifications to the ISP and individual budget will occur within five working days of the date of verbal service authorization.

Crisis Intervention and Stabilization Supports

Staff trained in crisis services competencies are available to provide “first response” crisis services to individuals they support, in the event of a crisis:

- Assess the nature of the crisis to determine whether the situation can be stabilized in the current location or if a higher-level intervention is needed.
- Determine and contact agencies needed to secure higher level intervention or out-of-home services.
- Provide direction to staff present at the crisis or provide direct intervention to de-escalate behavior or protect others living with the individual during behavioral or medical episodes.
- Contact the Care Manager within 48 hours following the intervention to arrange for a treatment team meeting for the individual and/or provide direction to service providers who may be supporting the individual in day programming and community settings, such as direct intervention to de-escalate behavior or protect others during behavioral episodes. This may consist of enhanced staffing provided by a QP to provide one additional staff person in settings where the participant may be receiving other services.

Out-of-Home Crisis Supports

Out-of-home crisis is a short-term service for an individual experiencing a crisis and requiring a period of structured support and/or programming. The service takes place in a licensed facility. Out of-home crisis may be used when an individual cannot be safely supported in the home, due to his/her behavior, and implementation of formal behavior interventions have failed to stabilize the behaviors, and all other approaches to ensure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver participants who have heightened behavioral needs. Out-of-home crisis services are authorized in increments of up to 30 calendar days.

Crisis Consultation

Crisis consultation is for individuals that have significant, intensive, or challenging behaviors that have resulted or have the potential to result in a crisis situation. Consultation is provided by staff that meets the minimum staffing requirements of a Qualified Professional, who have crisis experience. Non-licensed staff must meet the core competency requirements outlined in the waiver and the activities performed by non-licensed staff must be overseen by licensed staff with experience serving individuals with IDD and behavioral health needs.

Community Living and Support (base budget service)

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

- Enables the person to learn new skills, practice and/or improve existing skills. Areas of skill acquisition are interpersonal, independent living, community living, self-care, and self-determination.
- Provides supervision and assistance for the person to complete an activity to his/her level of independence. Areas of support consist of assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, and interpersonal skills.
- Provides technical assistance to unpaid supports who live in the home of the individual to assist the individual to maintain the skills they have learned. This assistance can be requested by the unpaid support or suggested by the Individual support planning team and must be a collaborative decision. The technical assistance is incidental to the provision of community living and supports.
- Community living and supports (exceptional needs) are used to meet exceptional, short term situations that require services beyond 12 hours per day. The ISP documents the exceptional supports needed based on the SIS™ or other assessments that explain the nature of the issue and the expected intervention. A plan to transition the individual to sustainable supports is required.

The plan may document the use of assistive technology or home modifications to reduce the amount of the support for behavioral and/or safety issues. Medical, behavioral, and support issues require documentation of when the situation is expected to resolve, evaluations/assessments needed to assist in resolving issues, and other service options explored. EPSDT and other appropriate State Plan services must always be utilized before waiver services are provided. All requests for community living and supports require prior approval by the LME/MCO.

Day Supports Individual; Group; Developmental Day (base budget service)

Day supports is a group service originating from a facility that provides assistance to the individual with acquisition, retention, or improvement in socialization and daily living skills and is one option for a meaningful day.

Day supports is typically provided in a group setting. Unless the following criteria are met and documented, Day supports – group should be the service sought. Individual day support is available to meet specific and well-documented needs of the person who cannot be served in the group. These circumstances may include the provision of individual supports due to behavioral or psychiatric destabilization, medical concerns/necessity, or other infrequent and exceptional circumstances. Individual day supports related to medical/behavioral/physical support needs shall require supporting medical or behavioral records and accompanying documentation in the ISP supporting the need for individual services as the most appropriate option.

For working-age individuals (ages 16 and older) not also working in competitive integrated employment, day supports may include career and employment exploration through educational and experiential opportunities designed to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to competitive integrated employment. It also typically includes business tours, informational interviews and job shadows, related to the person's identified interests, experiences and/or skills, in order to explore potential opportunities

for competitive integrated employment in the person's local area. For individuals who are aging, day supports can provide a structured day program of service and support with nursing supervision in an adult day care program.

Additionally, adult day health services similar to adult day care programs in that they provide an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being

"Facility-based" means that individuals who receive this service are often in a licensed day supports provider facility that serves individuals with intellectual and developmental disabilities. Individuals who receive day supports only have to attend the day supports facility once per week and therefore are often in the community with individuals without intellectual and developmental disabilities. The costs of transportation to and from the facility, for individuals not in school, are to be provided by the day support program and the additional transportation time is already accounted for in the service rate (transportation times are not billable service units). Transportation to and from school settings is not included for individuals who are eligible for educational services under the Individuals with Disabilities Educational Act.

Developmental day is provided in day care settings with children who do not function with an intellectual or developmental disability. For individuals who are aging, day supports can provide a structured day program of service and support with nursing supervision in an adult day care program. Additionally, adult day health services similar to adult day care programs in that they provide an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. Developmental day is a service which provides individual habilitative programming in a licensed child care center. It is designed to meet the developmental needs of the child in an inclusive setting to promote skill acquisition in areas such as self-help, fine and gross motor skills, language and communication, cognitive and social skills in order to facilitate their functioning in a less restrictive environment. For individuals who are eligible for educational services under the Individuals with disability educational act, day supports will be the payer of last resort for developmental day.

Day supports emphasizes inclusion and independence with a focus on enabling the individual to attain or maintain his/her maximum self-sufficiency, increase self-determination and enhance the person's opportunity to have a meaningful day. Individual day supports are available to meet specific and well-documented needs of the person. These circumstances may include the provision of individual supports due to behavioral or psychiatric destabilization, medical concerns/necessity, or other infrequent and exceptional circumstances.

Home Modifications (non-base budget)

Home modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned by the participant or his/her family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to

perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant. A physician's signature certifying medical necessity shall be included with the written request for home modifications. Home modifications are not available to individuals who receive residential supports.

Items that are not of direct or remedial benefit to the participant are excluded from this service. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (i.e. improving entrance/egress to the residence of configure a bathroom to accommodate a wheelchair). Central air, general plumbing, swimming pools, Jacuzzis/whirlpool tubs, fences, service and maintenance contracts and extended warranties, and any item utilized as a restraint are all excluded.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired. The requested modification must be prior approved before the home modification is purchased and/ or before the home is modified. Once approved, the modification has to be completed based on what was submitted for approval. Any changes to the modification and/or to the cost of the modification requires prior approval. Assistive technology equipment and supplies and home modifications are limited to a combined total of \$50,000 over the life of the waiver.

You or your family are not allowed to pay the difference or share the cost of home modification services that have been authorized or paid for by the Innovations waiver.

Individual Goods and Services (non-base budget)

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

- The item or service would decrease the need for other Medicaid services, **AND/OR**
- Promote inclusion in the community, **AND/OR**
- Increase the person's safety in the home environment, **AND**
- The individual does not have the funds to purchase the item or service, **AND/OR**
- **This service is only available to individuals who self-direct at least one of their services.**

Natural Supports Education: Individual; Conference (non-base budget)

Natural supports education provides training to families and the participant's natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the participant, provide education and training on intervention/strategies, and provide education and training in the use of specialized equipment and supplies. The requested

education and training must have outcomes directly related to the needs of the participant or the natural support network's ability to provide care and support to the participant. In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver. The expected outcome of this training is to develop and support greater access to the community by the participant by strengthening his or her natural support network. The request must be prior approved before enrollment fees are paid to attend a class or conference.

The service does not include transportation, lodging and meals and is not available to family members and natural support networks when those members are employed to provide supervision and care to the member.

Residential Supports (non-base budget)

Residential supports consist of an integrated array of individually designed training activities, assistance and supervision, and include:

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

Residential supports are provided in a licensed/unlicensed community residential setting. Facility capacity for all newly developed facilities is four beds or less. Facility capacity for existing residential facilities is six beds. However, facilities greater than six beds that were "grandfathered" into the waiver at the time of the PIHP transition from CAP-I/DD to NC Innovations may continue to provide residential supports.

Residential supports may also be provided in an alternative family living (AFL) situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites must be licensed whenever supporting one or more minors or more than one adult. All AFL sites will be reviewed using an AFL checklist for health and safety related issues. Alternative family living residential support providers are limited to three beds or less.

Residential supports are provided in licensed residential settings that demonstrate a home and community character. A home and community environment is characterized by an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the individual and easy access to resources and activities in the community. Group homes are expected to be located in residential neighborhoods in the community. Meals are served family style and individuals access community activities, employment, schools or day programs. Each

facility shall assure to each individual the right to live as normally as possible while receiving care and treatment. Home and community character will be monitored by each LME/MCO through on-going monitoring. Care workers or care managers will monitor the home and community character of the group home during care management monitoring. Results of the monitoring will be reported to the LME/MCO and DHB. Providers found out of compliance are given a timeline in which to come into compliance.

- Care managers continue to offer participants choice of smaller facilities.
- Community navigators assist participants in transitioning to homes of their own.
- Residential supports daily rates include payments for relief staff that provide support for the participant in the group home or alternative family living home.
- Transportation to and from a licensed day program is the responsibility of the residential supports provider.

Supportive Living (non-base budget)

Supported living provides a flexible partnership that enables a person/s to live in their own home with support from an agency that provides individualized assistance in a home that is under the control and responsibility of the person/s. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the individual/s, budget management, attending appointments, and interpersonal and social skills building to enable the individual to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the person to participate in home life or community activities. Other activities include assistance with monitoring health status and physical condition, and assistance with transferring, ambulation and use of special mobility devices. Transportation is an inclusive component of supported living to achieve goals and objectives related to these activities with the exception of transportation to and from medical services covered through the Medicaid State Plan.

This service is distinct from residential supports in that it provides for a variety of living arrangements for individuals who choose to live in their own home versus the home of a provider. A person's own home is defined as the place the person lives and in which the person has all of the ownership or tenancy rights afforded under the law. This home must have a separate address from any other residence located on the same property. Persons living in a supported living arrangement shall choose who lives with him/her, are involved in the selection of direct care staff, and participate in the development of roles and responsibilities of staff. Persons receiving supported living have the right to manage personal funds as specified in the ISP. A formal roommate agreement, separate from the landlord lease agreement, is established and signed by individuals whose name is on the lease. Supported living can be a self-directed service.

Respite (base budget service)

Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. Respite may include in and out-of-home services, inclusive of overnight, weekend care, emergency care (family emergency based, not to include out-of-home crisis). 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.

This service is not available to participants who live alone or with a roommate in their own home or apartment. NC Innovations respite may also be used to provide temporary relief to individuals who reside in licensed and unlicensed AFLs, but it may not be billed on the same day as residential supports. Respite can be used to support an individual in residential services or supported living.

Note that staff sleep time is never a billable service. It includes transportation from the participant's residence to points of travel in the community. NC Innovations respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as residential supports.

Specialized Consultative Services (non-base budget)

Specialized consultative services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy or nutrition and other licensed professionals who possess experience with individuals with intellectual or developmental disabilities to assist family members, support staff and other natural supports in assisting participants with developmental disabilities who have long term intervention needs. Under this model, family members and other paid or unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the ISP, therefore increasing the effectiveness of the specialized therapy.

This service will also be utilized to allow specialists defined to be an integral part of the individual support team to participate in team meetings and provide additional intensive consultation and support for individuals whose medical and/or behavioral /psychiatric needs are considered extreme or complex. The participant may or may not be present during service provision. The professional and support staff are able to bill for their service time concurrently.

Supported Employment Services (base budget service)

Supported employment services provide assistance with choosing, acquiring, and maintaining a job for beneficiaries ages 16 and older for whom competitive employment has not been achieved and/or has been interrupted or intermittent. The intent of initial supported employment is to assist individuals with developing skills to seek, obtain and maintain competitive employment or develop and operating a micro-enterprise. The employment positions are found based on individual preferences, strengths, and experiences. Job finding is not based on a pool of jobs that are available or set aside specifically for individuals with disabilities.

The transition to long-term supported employment should occur within one year of successful competitive employment, at this time it is expected that staff time will reduce as the individual becomes more independent in her/his job duties. Supported employment may be needed if the individual's job duties change or if a new job is acquired. Feedback regarding the success and integration of the individual into their position should be obtained from the employer, through employee evaluations that provide information on the level of supervision and oversight that the individual requires on a daily basis. Part of the responsibility of the employment specialist is providing education to the employer regarding ADA accommodations, in an effort to ensure the

transition from ongoing supported employment to long-term follow-up is successful and the individual's needs are met.

Long-term follow up may be used on a regular basis to meet specific and well-documented needs. Long-term follow-up related to medical/behavioral/physical support needs require medical behavioral records and accompanying documentation in the ISP supporting the need for individual services as the most appropriate and viable option.

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

While it is not prohibited to both employ a beneficiary and provide service to that same beneficiary, the use of Medicaid funds to pay for supported employment services to providers that are subsidizing their participation in providing this service is improper. The following types of situations are indicative of a provider subsidizing its participation in supported employment:

- The job/position would not exist if the provider agency was not being paid to provide the service.
- The job/position would end if the beneficiary chose a different provider agency to provide service.
- The hours of employment have a one to one correlation with the amount of hours of service that are authorized.

Vehicle Modifications (non-base budget)

Vehicle modifications are devices, services or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance and training in the care and use of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident.

Modifications do not include the cost of the vehicle or lease. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines. A physician's signature certifying medical necessity shall be included with the written request for vehicle modifications.

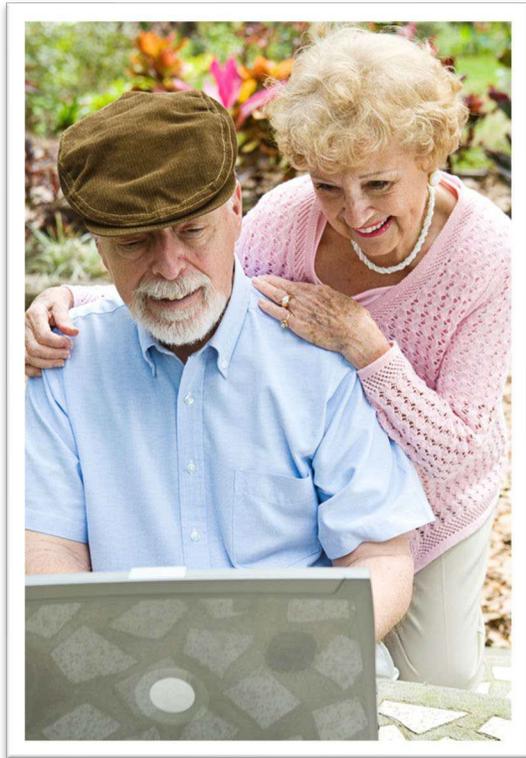
Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

The requested modification must be approved before the vehicle is modified. Once approved, the modification has to be completed based on what was submitted for approval. Any changes

to the modification and/or to the cost of the modification requires prior approval. The family/participant/legally responsible person cannot pay additional costs to the provider beyond what Medicaid has paid for.

Vehicle modifications are not available to participants who receive residential supports. Modifications needed to a vehicle owned by a provider are the responsibility of the provider and are not covered by this service. You or your family are not allowed to pay the difference or share the cost of vehicle modification services that have been authorized or paid for by the Innovations waiver.

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



Section 4: Approval of Your Individual Support Plan and Service Authorization

This section of the guide provides an explanation of:

**Submitting the Individual Support Plan
to Utilization Management for Approval**

Service Limitations

Utilization Criteria

Service Authorization

Submitting the Individual Support Plan to Utilization Management

The Individual Support Plan (ISP) belongs to the participant. The planning process is person-centered and directed/facilitated by the participant to the extent they desire. The ISP identifies strengths and capabilities, desires and support needs. When the ISP is completed, you (or your legally responsible person, if applicable) will be asked to sign the plan. There is a place on the ISP to indicate if you do not agree with the plan and an area to explain your concerns. Your Care Manager then submits the plan to the I/DD utilization management department for review and determination of medical necessity of the requested services. The ISP must be signed in order to be approved.

Care Managers will review the ISP with the enrollee before it is signed, will answer any questions the enrollee has, and will make any changes to the plan that the enrollee requests before the enrollee is asked to sign it. The ISP should contain the level of services that you request, which may be different than the level of services that will be approved. Information that the Care Manager submits to utilization management includes:

- Contact information for the care manager.
- Individual Support Plan, including crisis plan.
- Individual budget for planned services.
- Level of care (initial requests only).
- Risk/support needs assessment.
- Additional assessments by the appropriate professional, as needed, including the Supports Intensity Scale (SIS)[™].
- Positive behavior support plan, if applicable.
- Physician orders, as applicable.
- Service specific information such as fading plans and details about equipment being requested.
- Plan for how any requested equipment will be utilized with training outcomes, as applicable.

From the date the information is submitted, the I/DD utilization management department has 14 days to review the request and approve, deny, or ask for additional information. If additional information is requested then up to (but not longer than) an additional 14 days may be requested to complete the review. You will receive a letter notifying you if additional information has been requested and telling you the timeframe within which that information is due.

Medically Necessary Treatment

In order for NC Innovations to cover (pay for) treatment (services) those services must be deemed “medically necessary.” This means treatment and services must be:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative or restorative treatment of a mental health or substance abuse condition.

- Consistent with Medicaid policies and National or evidence based standards, North Carolina DHHS defined standards, or verified by independent clinical experts at the time the procedures, products and services are provided.
- Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care.
- Not provided solely for the convenience of the individual, family members, custodian or provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- Furnished by or under the supervision of a licensed professional (as relevant) under state law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable federal and state directives;
- Sufficient in amount, duration and scope to reasonably achieve their purpose, and
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, and duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment shall be designed to:

- Be provided in accordance with the person-centered ISP which is based upon a comprehensive assessment, and developed in partnership with the person receiving services (or in the case of a child, the child and the child’s family or legal guardian) and the community team;
- Conform with any advanced medical or mental health directives that have been prepared;
- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

Denial of Services/Appeal Rights

If any service requested in your ISP is denied, reduced or terminated, you have the right to appeal. A written explanation of the decision and appeal rights are mailed to you or your legal guardian, if applicable. For more information on your appeal rights refer to the Alliance Individual and Family Handbook. Watch your mailbox for your appeals explanation. Remember to notify your Care Manager and Medicaid care worker at DSS if your mailing address changes.

Your Care Manager can help you with any information needed for your appeal. The North Carolina MH/DD/SAS Plan requires that you go through the local reconsideration process prior to the appeals process. Reconsideration is an opportunity for you to work with Alliance to present additional information and/or clarify new information regarding the denied service.

Please note that appeal rights are not given for adult enrollees (age 21 and older) if services have been approved up to the maximum benefit set forth in the waiver.

Alliance will never retaliate against you if you choose to appeal.

Service Limitations

Limits on sets of services (services provided in combination) are intended to be maximum amounts of services for individuals with exceptional disability needs. Limits on sets of services apply to the following NC Innovations services per plan year and are subject to change with each waiver renewal:

- Community networking services.
- Day supports.
- Community living and supports
- Supported employment.

Other Types of Limitations

Each service definition has additional limitations that are listed in the waiver and in NC DHB Clinical Coverage Policy 8P. Your Care Manager can help you understand the limits that apply to the services you are requesting.

These limits include:

- Services that cannot be provided at the same time of day as other services.
- Services that cannot be provided on the same day as other services.
- Services that cannot be provided if you receive other services.
- Services that can only be provided if you self-direct services.
- Services that have spending limits per year or over the duration of the NC Innovations waiver.
- Services that cannot be provided in certain locations.
- Services that have other conditions on their use.

Utilization Criteria

Alliance is allowed by contract with the Division of Health Benefits to set utilization criteria for services approved by its utilization management department. If you have specific questions or would like to see these criteria, your Care Manager or someone from the I/DD utilization management department will assist you.

I/DD utilization management care managers will review the information submitted by your Care Manager against a set of criteria that includes:

- Information that clearly states why the service/equipment is related to your disability.
- Utilization management criteria.
- Practice guidelines.
- Individual Support Plan approval criteria.
- Individual budget guideline.

As a result of that review, the I/DD utilization management care manager will approve the authorization for the services requested or refer for higher level review. Decisions to reduce or

deny a request for authorization of a service can only be made by an Alliance licensed psychologist or medical doctor. Denials or reductions in services can be appealed. See page 43 for more information.

Service Authorization

All NC Innovations waiver services must be approved in the person-centered ISP and be authorized to allow the provider agency to bill Alliance. ISP approval and authorization is completed by the I/DD utilization management staff, called care managers.

You will receive a copy of your ISP and the approval letter from your Care Manager once the plan has been approved. Your provider agency is notified by utilization management when your services are approved (authorized). Your services can begin once the provider agency, employer of record, or agency with choice receives the authorization that allows the agency to bill Alliance for services provided.

If some services are approved and some are denied, you can receive the services that were approved while you appeal the services that were denied if you choose. You may also make a new request for different services while the appeal is pending, if you choose to.



Section 5: Implementing Services

This section of the guide provides an explanation of:

Alliance Health's Provider Network

Starting Your Services

The Alliance Health Provider Network

Alliance maintains a provider network by contracting with qualified providers who are culturally competent, demonstrate competencies in best practices and assure that services are delivered in a timely and appropriate manner. The network is geographically and clinically diverse enough to ensure adequate access to all services covered through NC Innovations. The Alliance network of providers will also ensure your health and safety as well as demonstrate ethical and responsible practices. Your satisfaction and achievement are the priority of the Alliance network providers.

Provider Responsibilities

- Participating in Individual Support Plan (ISP) and other service planning meetings with you, your Care Manager, and your family.
- Recruiting qualified staff and making sure staff are privileged, trained and supervised in providing services.
- Implementing the services authorized by the Alliance Utilization Management Department as written in the ISP.
- Developing short-term goals as decided upon at the ISP meeting as well as training strategies/task analysis to achieve your goals.
- Monitoring services to ensure that they are implemented as outlined in the ISP and agreed upon short-range goals.
- Reviewing and maintaining documentation of services that is adequate to support progress.
- Notifying the Care Manager of significant changes in your situation, needs and service delivery.
- Providing services based on the individual's ISP and billing for those services as authorized and provided.
- Providing back-up staff when the scheduled direct service employee is unavailable.

Selecting Service Providers

During the development of your ISP, you need to decide which network provider best meet your needs. Your Care Manager provides you with a list of approved providers in your area who offer the services you need. You need to decide which one(s) will be the best for you.

Some questions you might want to ask provider agencies are:

- Do you provide the services I need?
- How do you train your employees?
- Can I meet with the worker before he or she is placed in my home?
- Whom do I call if I am having problems with a worker?
- What can I do to help the provider agency know what my needs are?
- What are the steps to follow if the worker does not show up for work and a substitute needs to be arranged?

- Will you train your employees throughout the year as it relates to the method we are using (for example, training on how to handle a certain behavior, etc.)?
- Do you provide the supplies needed for objectives (for example, if the objective is to put together a puzzle, do you provide the puzzle)?
- Do you have people qualified to provide more than one service? Which ones?
- How frequently and by what method is the employee supervised by your agency? When will you do the home visits to observe services?
- Will the agency call me to notify me of the home visit?

Starting Your Services

Implementation of the ISP is a shared responsibility of you, your family members, and the members of your planning team. Services must start within **45 days of initial ISP approval**.

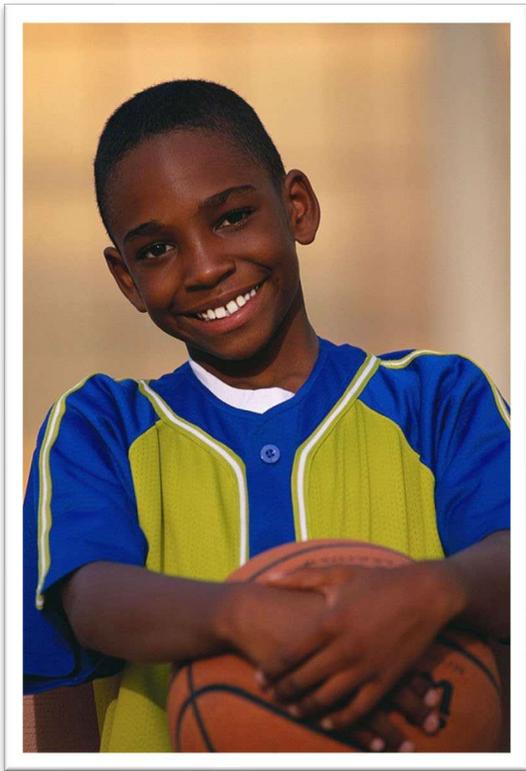
Timelines

Your initial ISP must be submitted for approval **within 60 days of the level of care determination date**.

Your annual ISP will be effective the first day of the month following your birth month. For the initial, annual and updated ISP, all plans must be approved prior to services beginning. If plan approval is denied, appeal rights will be offered. Following any ISP or update to the ISP services should begin promptly. If services do not begin promptly, it may be necessary to revise your ISP. If you wish to change or add services during the plan year, you may ask your Care Manager to assist in updating your ISP at any time.

After Your Individual Support Plan is Approved

- The network provider agency of your choice develops short-term goals and task analysis/strategies to assist the staff to consistently implement long-range outcomes.
- Back-up staffing will be identified in the event that a direct service employee is unable to assist you due to staff absence.
- DSS is notified by Alliance so that the NC Innovations indicator can be placed on your Medicaid record.



Section 6: NC Innovations Policies and Procedures

This section of the guide provides an explanation of:

**Monitoring of Services by the
Care Worker or Care Manager**

**Minimum Use of Services to Remain
on NC Innovations Waiver**

Traveling Out of State

**Relatives and Legal Guardians
as Direct Service Providers**

Other Helpful Information

Monitoring of Services by the Care Worker

Your Care Worker (SIC) is responsible for monitoring the implementation of your person-centered Individual Support Plan (ISP) and all other Medicaid services provided to you as well as your overall health and safety. Monitoring will take place in all service settings and on a schedule outlined in your plan.

Why is Monitoring so Important?

- To make certain services are provided as outlined in your plan.
- To make sure you have access to services.
- To identify problems as they arise so they can be resolved.
- To make sure the services you are receiving meet your needs.
- To assure that back-up staffing plans are implemented according to your plan.
- To make sure you are healthy and safe.
- To make certain you are offered a free choice of network providers.
- To make sure your non-waiver service needs are being addressed.

How Will Monitoring Take Place?

- Face-to-face contact with you and members of the ISP team.
- Telephone contact with you and members of the ISP team.
- Observation of services.
- Review of documentation and billing.

How Often Will Monitoring by my Care Worker Occur?

- If you are new to the waiver, you will receive monthly face-to-face visits for the first six months and then on the schedule in your plan, but no less than quarterly.
- If your services are provided by guardians and relatives living in your home, you will receive monthly face-to-face visits.
- If you live in a residential program, you will receive monthly face-to-face visits.
- If you choose to self-direct your services, you will receive monthly face-to-face visits.
- If you are not listed in one of the above categories, you will receive face-to-face visits on the schedule in your plan, but no less than quarterly.
- If you do not receive a face-to-face visit during the month, your Care Manager will have contact with you by telephone.

Minimum Use of Services Required to Remain on NC Innovations

NC Innovations individuals must use one waiver service each month to remain eligible for the waiver. Your person-centered ISP must contain at least one NC Innovations service that can be provided each month other than assistive technology, community transition, home modifications, vehicle modifications and respite.

If you do not use a waiver service each month, you will be notified by your care manager. If you do not use a waiver service within the next 30 days of the notification, you may be terminated from the waiver. Alliance must consult with the Division of Health Benefits prior to terminating a NC Innovations participant for non-use of waiver services. Anyone terminated from NC Innovations for non-use of waiver services is given their appeal rights.

Whenever you receive information about your appeal rights, it is very important that you review the information carefully and let your care manager or UM care manager know if you have questions.

If you are removed from NC Innovations due to non-use of services, you may request to re-enter NC Innovations at the completion of any termination or appeal process. If the request is granted and is made within the same waiver year, a plan to bring you back on the waiver will be developed. If the request to re-enter the waiver is made in a new waiver year, you may be placed on the Registry of Unmet Needs and have to wait if no waiver funding is available at the time of your request.

NOTE: For Alliance, the “waiver year” runs from July 1 to June 30.

Services Provided Outside North Carolina

If you decide to travel out of state and need the services of your NC Innovations staff, these guidelines are used to determine if your NC Innovation services can be funded through the waiver during your trip:

- Services for participants who have been receiving services from direct care staff while in state and who are unable to travel without their assistance.
- Participants who live in alternative family living homes or foster homes may receive services when traveling with their alternative family living or foster family out of state under these guidelines.
- Participants who are residing in residential settings are allowed to go out of state on vacation with their residential provider and continue to receive services as long as the participant’s cost of care does not increase.
- Written prior approval of this request for their staff to accompany families/participants out of state must be received from the supervisor of the staff person and the LME/MCO.

- Waiver services may not be provided outside of the United States of America.
- Provider agencies must ensure that the staffing needs of all their participants can be met.
- Supervision of the direct service employee and monitoring of care must continue.
- The ISP must not be changed to increase services while out of state.
- Services can only be reimbursed to the extent they would be had they been provided in state, and only if they benefit the participant.
- Respite services **are not** provided during out-of-state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive other state's licensure laws. A NC licensed professional may or may not be licensed to practice in another state.
- Medicaid funds cannot be used to pay for room, board, or transportation costs of the participant, family or staff.
- Provider agencies and agencies with choice assume all liability for their staff when out of state.

Relatives and Legal Guardians as Direct Service Providers

As we move forward under the North Carolina Innovations waiver, we felt it important to try to explain as clearly as we can the process for provider agencies and employers of record within the Alliance network to employ relatives/legal guardians as paid caregivers based on the guidelines in NC DHB Clinical Coverage Policy No. 8P.

Under NC DHB Clinical Coverage Policy 8P, relative as provider policy applies to waiver participants ages 18 and older who live with a relative or legal guardian who is employed by a provider agency contracted with Alliance Health to provide Innovations waiver services. Waiver beneficiaries under the age of 18 may not receive services provided by a relative who is residing in the same home.

Relatives are defined as individuals related by blood or marriage to the waiver participant. The relative must live in the home of the waiver participant. Biological or adoptive parents of a minor child, stepparents of a minor child or the spouse of a waiver participant are excluded from being employed as a relative as provider.

If the prospective employee is the legal guardian of the waiver participant, the guardian must be legally able to provide services as defined in NC House Bill 543.

Community living and support is the only waiver service that may be provided by a relative who resides in the home of the individual (age 18 and older).

It is recommended that a relative residing in the home of the waiver participant provide no more than 40 hours per week of service to the person. This must be reported to Alliance but does not require prior approval.

Provider agencies and employers of record are required to report relatives/legal guardians acting as paid supports to the waiver participant's Alliance I/DD Care Manager. The I/DD Care Manager must include this information in the waiver participant's Innovations ISP. The ISP must contain documentation that the waiver participant is in agreement with the employment of the relative and that he/she has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.

If more than 40 hours are requested to be provided by relatives residing in the home of the participant, then PRIOR APPROVAL must be obtained from Alliance.

All of the following justifications should be provided:

- Why there is no other qualified staff to provide community living and support.
- Assurances that the waiver participant had choice in staff.
- The waiver participant will not be isolated from his/her community.

In exceptional situations, up to 56 hours per week may be approved. This is the total number of hours that one relative may provide regardless of the number of waiver participants residing in the home.

Relatives who were providing more than 56 hours per week of service(s) on December 31, 2015, may exceed the 56 hour limit and be approved to provide the amount of services they were approved to provide as of December 31, 2015 as long as:

- The waiver participant continues to choose the relative as the staff member; AND
- There are no health and safety issues for the waiver participant; AND
- The waiver participant is not isolated from their community.

Alliance must ensure compliance with the conditions of this policy through a prior approval process. Alliance must provide an increased level of monitoring for services delivered by relatives/legal guardians. Services delivered by relatives/legal guardians are monitored monthly. The Alliance I/DD Care Managers monitor through on-site monitoring and documentation review to ensure that payment is made only for services rendered and that the services are furnished in the best interest of the individual. Provider agencies and employers of record must comply with all monitoring requests from I/DD Care Managers.

The relative or legal guardian will not be reimbursed for any activity that would be provided to a person without a disability of the same age. It is our hope that relatives are allowed to be just that, relatives, and provide the same natural supports they would any family member. Some of the questions provider agencies and employers of record should ask before employing a relative as provider:

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

- If a participant with a disability is always supported by a family member, what happens when that caregiver becomes unable, through age, disability or death, to care for the participant? Who else knows how to interact with and care for the participant?
- Can a family member be a barrier to increased community integration or friendship development?
- Does having a family member as direct support staff expand the participant's circle of support or risk shrinking it?

The application process asks about other potential non-relative employees that were interviewed, and why they were not appropriate. Alliance may require or offer the use of a neutral advocate (either through a Community Navigator or an advocacy organization such as Disability Rights NC) in this process to ensure that the desires and needs of the waiver participant are addressed by the ISP planning team.

When making decisions about whether to seek employment to provide Innovations waiver services to a ward, in addition to compliance with HB543, legal guardians have a duty to always act in the best interest of their ward and comply with the following legal requirements:

- Ensure that the guardianship is tailored to meet the *actual* needs of each individual ward.
- Make decisions that ensure the health and well-being of the ward, based on what the ward would decide if capable of making the decision.
- Involve the ward in all decisions to the extent possible.
- Allow the ward the opportunity to exercise rights that are within his/her comprehension and judgment, allowing the ward the same possibility for error as a person who is not incompetent.
- Support the ward in developing the necessary skills to assume responsibility for his/her own decision-making.
- Ensure the guardianship is periodically reviewed, and consider alternatives to guardianship, including restoration to competency or a limited guardianship.

In order to request approval for a relative/ legal guardian to serve as provider for more than 40 hours/week, the provider agency that currently employs or seeks to employ the relative/legal guardian must fill out the appropriate application and submit to Alliance.

This application must show that the relative/legal guardian meets the qualifications to provide the service and explain the justification for using the relative or legal guardian as the service provider rather than an unrelated provider. The request must be approved prior to service being provided by the relative/legal guardian to exceed 40 hours/week. Access the application form used to make this request at AllianceHealthPlan.org/wp-content/uploads/Relative-as-Provider-Application.pdf. Applications must be sent electronically via secure encrypted email to RelativeasProvider@AllianceHealthPlan.org.

If the application is incomplete, it will be returned to the provider agency and will not be processed. Providers are strongly encouraged to submit complete and timely applications.

Applications are reviewed by a subcommittee of the Alliance Credentialing Committee. This committee meets the fourth Tuesday of every month. Decisions are communicated by e-mail. If the request is approved, services must be provided in accordance with the authorization. Approvals are provider agency and relative/legal guardian specific. If the relative/legal guardian

as provider changes the waiver recipient's services to a new provider agency, and intends to provide more than 40 hours/week of service, the new provider must submit an application.

If a current relative as a provider is denied to provide more than 40 hours/week of service, there is a 60 day transitional period allowed to find a non-relative to provide those services over 40 per week. If the issue has not been resolved at that point, an additional 45 day extension may be granted. After that process, another 45-day extension may be granted if more time is needed to locate non-relative staff to provide the hours over 40/week. During the extension periods the provider is required to give an update of activities taking place to find a non-relative every 15 days to Alliance. There is no transitional period for denials when it is an initial request to provide over 40 hours/week. Participants or family members/guardians dissatisfied with a denial may file a grievance. If a request is denied, Alliance can help identify other agencies that may have non-relative staff available to serve the individual.

As the provider nears the end of its final extension (at least 15 days before) and has done its due diligence and cannot find a non-relative staff person and can document those efforts on a new application, then they can reapply for approval of the relative as provider to provide more than 40 hours/week.

Family members with questions about this process may contact Ramona Branch, Member Inclusion and Outreach Manager, at 919-651-8821.

Other Helpful Information

Absences, Relocations and Terminations

If you are absent from NC Innovations services, your Care Manager may need to take certain actions. The action needed depends on the nature of the absence. If you are hospitalized, placed in an ICF-IID, ICF or skilled nursing facility, admitted to a rehabilitation facility, admitted to a state psychiatric facility, or will be absent for 30 days or more, the Department of Social Services will direct the Care Manager about continuing Medicaid eligibility. You should keep your Care Manager informed of all absences or anytime you are admitted to a hospital or institution.

Transferring Innovations Services

NC Innovations waiver participants are currently legal residents (for the purpose of Medicaid eligibility) of the Alliance catchment area, which includes Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. If you move to another county outside the Alliance region and become a legal resident of another area, you are no longer eligible for Alliance's NC Innovations. Your Care Manager works with you in transferring your Innovations slot and services to the LME/MCO that you are moving to and terminates you from Alliance's NC Innovations. The Care Manager provides the receiving LME/MCO with all requested information needed with your written consent.

It is important that you apply to have Medicaid transferred to your new county of residence as soon as you move. The date of Medicaid transfer is the date the Innovations slot is transferred from MCO to MCO. It will take a few weeks or even a month or more for the Medicaid to transfer. Your Alliance Care Manager will work with you through your transition to assure there is not a lapse in services.

Terminations from NC Innovations

A person must be terminated from NC Innovations for any one of the following reasons:

- Department of Social Services terminates Medicaid eligibility.
- The person-centered ISP is not approved, (which can be appealed).
- Placement in an ICF-IID, skilled nursing, or PRTF facility.
- Relocation out of state.
- Death.
- Non-use of at least one waiver service (other than assistive technology, community transition, home modifications, vehicle modifications, or respite) each month.
- Voluntary withdrawal.
- The person no longer meets ICF level of care as determined by utilization management (which can be appealed).

When terminations from NC Innovations are necessary:

- Appeal rights are provided to the individual or legal guardian in writing by the agency terminating them from NC Innovations and/or Medicaid.
- For most terminations, the effective date is the last date of the month.
- All terminations are coordinated with the local Department of Social Services.

Other State Waivers That Might Meet Your Needs

Your Care Manager can assist you if you have questions about any of the other state waivers. **You may only receive funding from one waiver at a time.** Other waivers in North Carolina are:

- **CAP-C-Community Alternatives Program for Children**
Provides an alternative to nursing facility and hospital care for individuals up to 21 years of age who live in a private residence who have complex medical needs (medically fragile) and who have been ruled disabled by Disability Determination Services (ncdhhs.gov/dma/services/capc.htm).
- **CAP-DA-Community Alternatives Program for Disabled Adults**
Provides an alternative to nursing facility care for persons with disabilities who are age 18 and older and who live in a private residence (ncdhhs.gov/dma/services/capda.htm).

Other Services That Might Meet Your Needs

If you are terminated from NC Innovations you should ask your care manager about other services that you may be eligible for that could meet your needs. Available services will vary from person to person since some individuals will no longer have Medicaid coverage when they are terminated from NC Innovations. DSS will inform you if you will continue to have Medicaid coverage.

Suggestions for Improvement to NC Innovations

Your suggestions about ways to improve the NC Innovations waiver are always welcome. Some operational procedures can be changed by Alliance, while others require the approval of the state or Center for Medicare and Medicaid Services (CMS). Please talk with your Care Manager or any Alliance employee if you have suggestions for waiver improvements.

For more information, visit Alliance's website at AllianceHealthPlan.org and select the link to NC Division of Medical Assistance website for NC Innovations and the 1915(b)(c) waiver, which provides detailed information about services, provider qualifications, funding, utilization management, monitoring, and quality assurance.

Consumer and Family Advisory Committee (CFAC)

The Consumer and Family Advisory Committee (CFAC) membership consists of consumers and family members who receive mental health, intellectual or developmental disability and/or substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to Alliance administration and Board of Directors.

State statutes charge CFAC with the following responsibilities:

- Review, comment on, and monitor the implementation of the local business plan.
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.
- Review and comment on the Alliance budget.
- Participate in all quality improvement measures and performance indicators.
- Submit findings and recommendations to the State Consumer and Family Advisory Committee regarding ways to improve the delivery of mental health, intellectual or other developmental disabilities and substance use/addiction services.

For more information, call toll-free 800-510-9132 to be put in touch with someone at the Alliance CFAC.



Section 7:

Acronym List and Glossary of Words and Terms to Know

This section of the guide
provides a list of acronyms and
an explanation of words and terms used here

What the Acronyms in the Guide Mean

AFL	Alternative Family Living
CAP	Community Alternative Program
CMS	Centers for Medicare and Medicaid Services
DHB	Division of Health Benefits
DHHS	Department of Health and Human Services
DSS	Department of Social Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (\leq age 21)
HCBS	Home and Community Based Services Intellectual
ICF or ICF-IID	Intermediate Care Facility (for Individuals with Disabilities)
ID or I/DD	Intellectual Disability or Intellectual/Developmental Disability
IDEA	Individuals with Disabilities Education Act
IEP	Public School's Individual Education Plan
IQ	Intelligence Quotient
ISP	Individual Support Plan
LME	Local Management Entity
MCO	Managed Care Organization
MD	Medical Doctor or Physician
MH/DD/SA	Mental Health, Developmental Disability, Substance Abuse
PIHP	Prepaid Inpatient Health Plan
PRTF	Psychiatric Residential Treatment Facility
QP	Qualified Professional
SIS™	Supports Intensity Scale™
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	(Social Security) Supplemental Security Income
UM	Utilization Management

Glossary of Words and Terms to Know

Alliance Health: A multi-county Local Management Entity/Managed Care Organization (LME/MCO) that manages, authorizes and oversees the provision of waiver services for individuals with mental health, developmental disabilities and substance abuse needs whose Medicaid originates from Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.

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

Base budget category: base budget services include:

- Community networking services.
- Day supports.
- Community living and supports.
- Respite.
- Supported employment.

Care manager: Care managers conduct utilization management (authorization of services) for Alliance. They monitor progress on goals in the Individual Support Plan, make recommendations, and refer for additional or different services and amounts of services, and supports based on their findings.

Care team: Alliance staff who are qualified professionals offering care management through a multi-disciplinary team approach.

Centers for Medicare and Medicaid Services (CMMS or CMS): The unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

Community supports: Organizations that provide support to a person. Community supports may include advocacy organizations, community service organizations, faith-based organizations, civic organizations, and/or educational organizations.

Cost limit: The maximum amount of all waiver services (base budget plus other NC Innovations services) that an individual may receive annually while participating in the NC Innovations waiver. For NC Innovations this is \$135,000 per waiver year.

County Department of Social Services (DSS): The local (county) public agency that is responsible for determining eligibility for Medicaid benefits and for other assistance programs.

Department of Health and Human Services (DHHS): The state agency that includes both the Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. The website for North Carolina's DHHS is ncdhhs.gov/.

Developmental Center: A state operated ICF-IID facility (institution) that provides health and habilitation services to individuals with intellectual and/or other developmental disabilities. The developmental center for the Alliance catchment area is The Murdoch Center located in Butner, NC. Referrals to developmental centers can be made only by the Managed Care Organization (Alliance). NC Innovations funding cannot be used while in a developmental center.

Division of Health Benefits (DHB): The state agency responsible for Medicaid-funded services and the administration of the NC Innovations and NC MH/DD/SAS Health Plan. The website for North Carolina's Division of Health Benefits is [medicaid.ncdhhs.gov/](https://www.ncdhhs.gov/medicaid).

Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS): The state agency that works with DHB in the administration of the NC Innovations and NC MH/DD/SAS Health Plan. The website for North Carolina's DMH/DD/SAS is [ncdhhs.gov/mhddsas/](https://www.ncdhhs.gov/mhddsas/).

Freedom of choice: The right afforded an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services.

HCBS waivers: Home and Community Based Services waivers that allow states that participate in Medicaid to develop alternatives for individuals who would otherwise require care in institutions. NC Innovations is one of North Carolina's HCBS waivers.

Habilitation service: A service that assists an individual in learning or improving skills, including self-help, socialization, and other adaptive skills directed at maximizing an individual's independent functioning.

In-home services: In NC Innovations this includes in-home skill building, in-home intensive support, respite and personal care.

Institution: For purposes of NC Innovations, an institution is defined as a residential facility that is licensed and funded as an ICF-IID (Intermediate Care Facility/Individuals with Intellectual Disabilities). NC Innovations funding cannot be used in an institution, including ICFs-IDD, hospitals, skilled nursing facilities, and state developmental centers.

Intermediate care facility for individuals with intellectual disabilities (ICF-IID): A licensed facility that provides care and active treatment for individuals with intellectual disability and certain other developmental disabilities. This is the institutional placement that is "waived" when the NC Innovations waiver is chosen instead. ICF-IID facilities have four or more beds (most have six, some more than 100) and must provide active treatment to residents.

Least restrictive environment: The least restrictive/intensive setting of care sufficient to effectively and safely support an individual. Supporting an individual in the environment that is least restrictive is considered best practice.

Legal guardian or legally-responsible person: A person who has been appointed by a court of law to act as decision-maker for an individual deemed unable to make decisions on their own behalf. Parents of children under 18 are their children's legally responsible person, unless those rights have been taken away by the court. Once a person turns 18, they legally become their

own guardian unless the court deems otherwise and appoints a guardian representative (most often, a family member or friend unless there is no one available in which case a public employee is appointed).

Limits on sets of services: A maximum amount of a designated group of services that an individual can receive under a waiver.

LME/MCO: Local Management Entity/Managed Care Organization, the entity responsible for managing the behavioral health care for under-insured, uninsured, and the Medicaid population in its specific geographical or catchment area.

Medicaid: The joint federal and state program to assist states in furnishing medical assistance (health insurance) to financially eligible individuals. Federal law concerning the Medicaid program is located in Title XIX of the Act. NC Innovations services are provided under the Medicaid program. All NC Innovations participants have Medicaid coverage.

Medically necessary treatment: In order for NC Innovations to cover (pay for) treatment (services) those services must be deemed “medically necessary.” This means treatment and services must be:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition.
- Consistent with Medicaid policies and national or evidence based standards, North Carolina DHHS defined standards or verified by independent clinical experts at the time the procedures, products and services are provided.
- Provided in the most cost-effective, least restrictive environment that is consistent with clinical standards of care.
- Not provided solely for the convenience of the individual, family members, custodian or provider.
- Not for experimental, investigational, unproven or solely cosmetic purposes.
- Furnished by or under the supervision of a licensed professional (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable federal and state directives;
- Sufficient in amount, duration and scope to reasonably achieve their purpose, and
- Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, and duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment shall be designed to:

- Be provided in accordance with the person-centered Individual Service Plan which is based upon a comprehensive assessment, and developed in partnership with the person receiving services (or in the case of a child, the child and the child’s family or legal guardian) and the community team;
- Conform with any advanced medical or mental health directives that have been prepared;

- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

Medicare: Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with end-stage renal disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). While NC Innovations services are not provided under the Medicare program, some NC Innovations participants may have Medicare coverage in addition to Medicaid coverage.

Non-base budget: Services that are not part of the base budget. These services may be used based on the service definition and your needs. They must be included in your Individual Support Plan and approved by the utilization management department. The total of base budget and non-base budget services may not exceed the annual waiver limit of \$135,000 per year.

Most integrated environment: The least restrictive setting of care sufficient to effectively treat a participant. An integrated environment is one in which a person with a disability participates in the same activities and settings as non-disabled peers.

NC Innovations level of care: The document used in the NC Innovations waiver that records the specification of the minimum amount of assistance an individual must require in order to receive services in an institutional setting under the Medicaid State Plan. For the NC Innovations waiver the institutional level of care setting that corresponds to the level of care that must be met for NC Innovations participants is the intermediate level of care for individuals with intellectual disability and related conditions.

NC Innovations waiver: The NC Innovations waiver is a means of funding services and supports for individuals with intellectual disabilities and other related developmental disabilities who are at risk for institutional care in an intermediate care facility for individuals with IDD (ICF-IID) but who chose instead to remain in their own home and community. NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. Federal, state and local dollars fund Medicaid waivers. The NC DD/MH/SAS Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and developmental disabilities services are authorized for Medicaid participants in Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.

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

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

Natural supports: People who provide support, care and assistance to a person with a disability without payment for that support. Natural supports may include parents, siblings, extended family members, neighbors, church members, and/or co-workers, etc.

Participant: The person who is approved to receive services under the NC Innovations waiver.

Person-centered plan: The document that includes important information about the participant, their life goals, and the steps that they and the planning team need to take to get there. It also identifies support needs, and includes a combination of paid, natural supports from family and friends, and community supports.

Prepaid Inpatient Health Plan (PIHP): Alliance Health, as do all NC Local Management Entities/Managed Care Organizations (LME/MCOs), functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and developmental disabilities services are managed and authorized for Medicaid participants in the Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties.

Private home: The home that an individual owns or rents in his or her own right or the home where a waiver participant resides with other family members or friends. A living arrangement (house or apartment) that is owned or leased by a service provider is not a private residence.

Provider network: The agencies or professionals under contract with Alliance Health to provide authorized services to eligible individuals.

Registry of Unmet Needs: A registry that contains a list of individuals who are waiting for NC Innovations funding for identified needs, also known as the Innovations waitlist.

Risk support needs assessment: An assessment of factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include health risk (medical conditions that require continuing care and treatment), behavioral risk (behaviors or conditions that might cause harm to the person or others), and risk to personal safety (e.g. ability to make safe evacuation independently).

Service limit: The maximum amount of a specific service that can be received under NC Innovations waiver.

Service Records Manual (Records Management and Documentation Manual [APSM 45-2])
The DMH/DD/SAS document that provides the requirements for maintenance of client information, documentation of service provision, and confidentiality requirements.

Slots: The annual allocation of the number of individuals that may be served in NC Innovations. The Center for Medicare and Medicaid Services (CMS) and the NC General Assembly allows North Carolina to serve a given number of individuals on NC Innovations each waiver (calendar) year. This number is the number of "slots" available for that year.

State Plan: The term that refers to the Medicaid State Plan for Medicaid for the State of North Carolina that is approved by the Center for Medicare and Medicaid Services (CMS).

Supplemental Security Income (SSI): Social Security program that pays benefits to disabled adults and children who have limited income and resources.

Supports Intensity Scale (SIS)[™]: A nationally recognized assessment that measures the level of supports required by people with disabilities to lead normal, independent, quality lives in their home community.

Support services: Services that enable an individual to live in their community. These include services that can provide direct assistance to the individual, and/or services that provide assistance to the individual's caregivers and/or support staff.

Utilization Management Department (UM): The Alliance department responsible for approving Individual Support Plans and authorizing medically necessary services. Care managers work in the UM department.

Waiver year: The 12-month period that the Center for Medicare and Medicaid Services (CMS) uses to authorize, monitor and control waiver programs and expenditures. The waiver year begins on the effective date of the waiver approval and includes the 12 months following that date. For NC Innovations this is July 1 to June 30.

Appendix A

Participant Responsibilities of NC Innovations Waiver

(Insert name of PIHP)

NORTH CAROLINA DIVISION OF MENTAL
HEALTH, DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

Client:

Record Number:

PARTICIPANT RESPONSIBILITIES NORTH CAROLINA INNOVATIONS WAIVER

I understand that enrollment in the North Carolina (NC) Innovations waiver is voluntary.

I also understand that if enrolled I will be receiving waiver services instead of services in an intermediate care facility for Individuals with Intellectual Disabilities (ICF-IID). My Medicaid eligibility must continue to come from a county in a North Carolina Innovations area for me to continue to be eligible for the NC Innovations waiver and I must continue to meet all other waiver eligibility criteria.

- I understand that by accepting NC Innovations waiver funding that I am in need of waiver services to prevent an immediate need for ICF-IID facility services.
- I understand that to maintain my eligibility for this waiver I require the provision of **at least one waiver service monthly** and that failure to use a waiver service monthly will jeopardize my continued eligibility for the NC Innovations waiver. The services approved in my Individual Support Plan have been determined necessary to improve/support my disability.
- I understand that participants in the NC Innovations waiver live in private homes or in residential facilities licensed for six or fewer beds **and** if living in a facility the facility must also meet the home and community characteristics defined in the waiver. If I am currently a participant in NC Innovations or am transitioning to NC Innovations, my Care Manager has explained to me how these requirements apply to my current living arrangement.
- I understand if I choose to move to a facility during my participation in the waiver that is larger than six beds or does not meet the home and community characteristics defined in the waiver, I will no longer be eligible for the waiver.
- I understand that the total of my waiver services cannot exceed \$135,000 when I enter the waiver.
- I understand that at any time during my plan year, the total of my waiver services cannot exceed \$135,000 or I will no longer be eligible for the waiver.
- I understand if I select the NC Innovations waiver, I will have an Individual Support Plan (ISP) developed that reflects services to meet my needs. My Care Manager will explain the planning process and the establishment of my individual budget to me.

- My ISP will be re-developed annually prior to my birth month. I understand the NC Innovations waiver will deliver services according to my ISP.
- I understand that I may be required to pay a monthly Medicaid deductible if that is part of my financial eligibility for waiver services. My Care Manager can assist me in obtaining information on Medicaid deductibles from my local Department of Social Services.
- I understand that I will cooperate in the assessment process to include but not be limited to Supports Intensity Scale™ (no less frequently than every two years), NC Innovations Risk/Support Needs Assessment, and Level of Care. The NC SNAP may be used in lieu of the Supports Intensity Scale™ during the initial years of my participation in the NC Innovations waiver. The decision of when the NC SNAP is used in lieu of the SIS™ is made by the Division of Health Benefits (DHB).
- I understand that my ISP will be monitored and reviewed by my Care Manager, and that I can contact my care manager at any time if I have questions about my ISP, individual budget or the services that I receive.
- I understand that I have the right to choose a provider within (insert name of PIHP) provider network.
- I understand that I am required to meet with my Care Manager for care coordination/care management activities in the home or wherever my family member lives and/or all settings where services are provided to allow my Care Manager **access to all settings where services are provided**. The Care Manager will schedule meetings as often as needed in order to ensure appropriate service implementation and participant's needs are met. I may also request meetings.
- I understand that I am required to notify the Care Manager of any concerns regarding services provided.
- I understand that I am required to give adequate notice to the Care Manager of any change in address, phone number, insurance status, and/or financial situation prior to or immediately following the change.
- I understand that I am required to give adequate notice to the Care Manager of any behavior or medication changes as well as any change in health condition.
- I understand that I am required to attend appointments set by the Department of Social Services (DSS) to determine Medicaid renewals to ensure my continued Medicaid eligibility.
- I understand that I will be provided a copy of educational information about the NC Innovations waiver to assist with my understanding the services available through the NC Innovations waiver and guidelines that needs to be followed to ensure continued eligibility.
- I understand that (insert name of PIHP) is responsible for ensuring an adequate network of provider agencies is available to promote choice for the participant.
- I understand that (insert name of PIHP) will make a Care Manager available to provide care coordination/care management supports which include:
 - Assessment to determine service needs to include but not be limited to the NC Innovations Risk/Support Needs Assessment.

- Working with the Individual Support Planning Team to coordinate and document the Individual Support Plan (ISP).
- Requesting any and all services under the Innovations waiver as listed in the ISP.
- Making the participants aware of the amount of their Individual Budget and the process used to establish this budget and make any needed changes.
- Monitoring all authorized services to ensure that they are provided as described in the ISP and that meet the participant’s needs.
- Assisting the participant with the coordination of benefits through Medicaid and management of other sources to include, if needed, linkage with the local Department of Social Services regarding coordination of Medicaid deductibles.
- Responding to any complaints or concerns and reach resolution within 30 days of the complaint regarding NC Innovations services.
- Promoting the empowerment of the participant to lead as much of his/ her Individual Support Planning, decision-making regarding the use of waiver dollars and oversight of waiver services as they choose.
- Obtaining an order from the participant’s physician for all needed medical supplies and specialized equipment.
- Supporting the participant in obtaining all needed information to make an informed choice of provider within the (insert name of PIHP) network, inclusive of notifying the (insert name of PIHP) Network Management Department if providers are needed outside of the current (insert name of PIHP) Network.

Name of Participant

Date

Signature of Participant
(or Authorized Representative)

Date

Appendix B

NC Innovations Service Limitations

Participant Age/Status	Living in Residential Setting, including AFL	Living in Private Home
Adult	No more than 40 hours per week any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports <i>and/or</i> • Supported Employment Services May receive up to one daily unit of Residential Supports	No more than 84 hours/week any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports • Supported Employment • Community Living and Supports
Child during school year (Ages 0 to 17 unless 18 and older and enrolled in school)	No more than 20 hours per week any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports <i>and/or</i> • Supported Employment • Services May receive up to one daily unit of Residential Supports	No more than 54 hours/week any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports • Supported Employment • Community Living and Supports
Child when school is not in session (Ages 0 to 17 unless 18 and older and enrolled in school)	No more than 40 hours per week of any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports <i>and/or</i> • Employment Services May receive up to one daily unit of Residential Supports	No more than 84 hours/week of any combination: <ul style="list-style-type: none"> • Community Networking • Day Supports • Supported Employment • Community Living and Supports

Services Not Subject to Limits on Sets of Services

<p>Additional Services contained in the Individual Budget</p>	<ul style="list-style-type: none"> • Respite (AFL only) 	<ul style="list-style-type: none"> • Respite
<p>Additional Services: Add On to Individual Budget</p>	<ul style="list-style-type: none"> • Assistive Technology, Equipment and Supplies • Community Navigator • Community Transition • Crisis Services • Natural Supports Education • Specialized Consultation Services 	<ul style="list-style-type: none"> • Assistive Technology, Equipment and Supplies • Community Navigator • Community Transition • Crisis Services • Home Modifications • Natural Supports Education • Specialized Consultation Services • Vehicle Modifications
<p>Available to Participants Who Self-Direct service(s)</p>	<ul style="list-style-type: none"> • Individual Goods and Services • Financial Support Services 	<ul style="list-style-type: none"> • Individual Goods and Services • Financial Support Services

Record of Review and Revisions

DATE	PAGE/SECTION	DESCRIPTION
June 2012	Entire Document	CFAC, DMA, Interdepartmental Review
April 2013; August 2013	Entire Document	Reviewed by IDD staff; no revision necessary; Interdepartmental Approval
November 2013	Entire Document	Reviewed by IDD; updates/revisions as needed throughout; Major revision to section on Relatives and Legal Guardians as Direct Service Providers; Interdepartmental Review
April 2014	CEO Message	Reflected staff change
October 2014	Entire document	Reviewed by IDD; updates/revisions as needed throughout; Revised waiver year; Added three service definitions; DMA and Interdepartmental Review
April 2015	Entire document	Reviewed by IDD; updates/revisions as needed throughout; Major revision to sections: Provider Directed vs. Individual and Family Directed Supports and Relatives and Legal Guardians as Direct Service Providers. DMA and Interdepartmental Review
December 2015	Entire document	Changes to language concerning IDD due process rights DMA and Interdepartmental Review
August 2018	Entire document	Reviewed by IDD; updates/revisions as needed throughout; DMA and Interdepartmental Review
November 2019	Entire document	Reviewed by IDD; updates/revisions as needed throughout; DHB and Interdepartmental Review
September 2021	Entire document	Updated language and roles for Care Teams, added JCB362 language allowing budgets in excess of \$135K
October 2022	Entire document	EQRO and county realignment revisions
February 2024	Entire document	Add Harnett County references