



NC TBI Waiver

INDIVIDUAL

and

FAMILY

Guide

The logo for Alliance Health features a stylized green 'A' icon to the left of the word 'Alliance' in a bold, blue, sans-serif font. Below 'Alliance', the word 'Health' is written in a smaller, green, sans-serif font.



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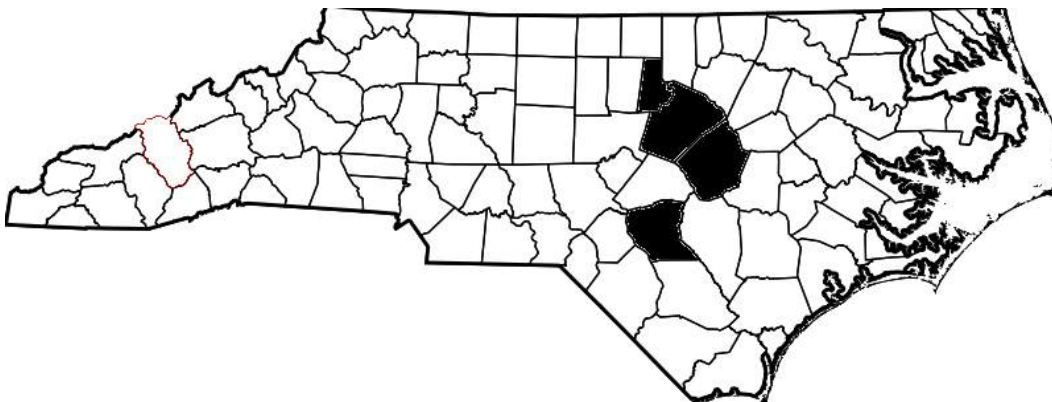
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This handbook is available in Spanish and in alternate formats. If you need a larger-print version, or have limited reading ability, call Alliance Health at (800) 510-9132.

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

Si necesita información en español, llámenos al 1-800-510-9132.

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





A Message from Rob Robinson Chief Executive Officer

Welcome to the NC TBI Waiver. This guide is designed to provide information about the NC TBI Waiver that will help you better understand the services and supports that can be funded through the NC TBI 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, at any time, you have questions or would like additional information about NC TBI Waiver, please contact your Alliance Care Coordinator 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 Coordinator 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 our **Alliance Access and Information Center 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 have been 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!

Rob Robinson

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

The NC TBI Waiver is a Medicaid Home and Community-Based Waiver (HCBS)

This section provides an explanation of:
**Purpose and Goals of NC TBI Waiver
Required Basic Service Elements**

Medicaid Home and Community-Based Services (HCBS) Waivers

Medicaid is a federal program originally designed to provide medical care and institutional services for people with disabilities, pregnant women, the elderly and children. 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 TBI Medicaid Waiver

The North Carolina TBI Waiver is a means of funding services and supports for people who would otherwise qualify for services in:

- Hospitals who have specialized care for persons with brain injuries who have significant cognitive, behavioral and rehabilitative needs.
- Specialized nursing facilities (SNFs) with services to support people with brain injury who have significant cognitive, behavioral and rehabilitative needs.

The NC TBI Waiver is authorized as 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 was approved for the Alliance LME/MCO catchment area to be effective May 1, 2018 and available for three years. This TBI Waiver operates concurrently with the 1915 (b) Waiver, and 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) in which all mental health, substance abuse and developmental disabilities services are authorized for Medicaid beneficiaries.

Local Management Entities (LMEs)/Managed Care Organizations (MCO)s are the local area authorities in the State of NC which are responsible for certain management and oversight activities with respect to publicly-funded MH/DD/SAS services and are PIHPs for the waiver.

Alliance Health (ABH) is the Local Management Entity/Managed Care Organization (LME/MCO) serving people in Wake, Durham, Cumberland and Johnston counties. Alliance manages a network of providers that offer services for people who are experiencing mental illness, substance use disorders, intellectual/developmental disabilities and traumatic brain injury.

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

The Division of Health Benefits (DHB), the State Medicaid agency, operates the NC TBI Waiver. DHB contracts with the MCO (PIHP) to arrange for, manage the delivery of services, and perform other waiver operational functions under the concurrent 1915 (b)/(c) waivers. DHB

directly oversees the NC TBI Waiver, approves all policies and procedures governing waiver operations and ensures that the NC TBI Waiver assurances are met.

The initial NC TBI Waiver will provide an array of home and community based services through a three-year Medicaid waiver pilot, in Alliance's four-county region.

Adults with cognitive, behavioral and or physical support needs.

- Individuals who have sustained a diagnosed TBI on or after their 22nd birthday.
- Adults who meet specialty rehabilitation hospital or skilled nursing level of care and who meet financial eligibility requirements may be eligible to participate in this Medicaid waiver.

What Medicaid Rules are “Waived” for NC TBI?

Statewidehood

The Social Security Act requires Medicaid services to be provided on a statewide basis. This requirement is waived to limit NC TBI Waiver participants to legal residents (for the purpose of Medicaid eligibility) of the PIHP (Prepaid Inpatient Health Plan) Region. The TBI Waiver is only for individuals who reside in the Alliance catchment area. Alliance manages the PIHP for residents of Durham, Wake, Johnston and Cumberland counties effective May 1, 2018.

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 TBI Waiver services to be offered only to individuals participating in the NC TBI Waiver.

Deeming of Income and Resources

Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This is "deeming" income and resources to the Medicaid recipient. The deeming requirement is waived to allow Medicaid eligibility for NC TBI Waiver participants to be considered similar to the methods used for people who are residing in skilled nursing facilities, ICF-IID group homes or the State Developmental Centers.

Purpose and Goals of NC TBI Waiver

The NC TBI Waiver is designed to provide an array of community-based rehabilitative services and supports that facilitates recovery and promotes choice, independence and community involvement. These services provide a community-based alternative to institutional care for persons who continue to require Neuro-Behavioral level of care or require a skilled nursing facility level of care.

The Goals of the NC TBI Waiver

The TBI Waiver will achieve to the fullest extent possible the following goals:

- Value and support waiver members to be fully functioning individuals of their community.
- Promote rehabilitation; evidence-based practices, and promising practices that result in real life outcomes for members.
- Offer person-centered service options that will facilitate each member's ability to live in homes of their choice, to be employed or to be involved in meaningful activities of the member's choice during the day and to achieve their life goals.
- Provide the opportunity for all members to contribute to the development of their services and supports.
- Provide training and support to foster the development of strong natural support networks that enable members to be less reliant on formal support systems.
- Ensure the well-being and safety of the people served.
- Maximize the member's self-determination, self-advocacy and self-sufficiency.
- Increase opportunities for community integration through work, life-long learning, recreation and socialization.
- Provide quality services and improve outcomes.

Objectives in the NC TBI Waiver include:

- Enhancing the focus on person-centered planning and aligning services and supports with those plans.
- Facilitating smaller community where individuals can choose the people they are living with.
- Facilitating living and working with non-disabled individuals.
- Improving outcome-based quality assurance systems.

Basic Service Elements for NC TBI Waiver

The following required elements must be included in all waiver supports and services provided through the NC TBI Waiver.

Care Coordination

Care Coordinators are Qualified Professionals (QPs) in North Carolina's credentialing system with competencies in person-centered planning who work for Alliance. Care Coordinators and NC TBI Waiver participants stay in contact as frequently as necessary, especially as needs change. TBI participants and/or their legal guardian are responsible for immediately notifying their Care Coordinator of any emergency situation or other circumstance that could affect their life and require a change in the person-centered Individual Support Plan (ISP). Please also notify your Care Coordinator of any changes in your address or contact information. If you don't know or don't remember who your Care Coordinator is, please contact Alliance at (800) 510-9132.

Care Coordinators assist people in the following ways:

- Identifying and documenting needs for services and supports.
- Developing, with the individual, family and other people of the individual's choice, the person-centered Individual Support Plan with long range outcomes.
- Assuring that short range goals are developed by the provider agency in accordance with the annual plan.
- Identifying choices and coordinating services.
- Monitoring for health and safety risk to assure that services are provided according to the Individual Support Plan and that those services continue to meet the person's needs and are to their satisfaction.
- Problem resolution and complaint reporting.
- Crisis intervention when needed.

Person-Centered Planning: Individual Support Plan

The Individual Support Plan is developed using a person-centered planning process. It is led by the individual with a TBI and/or legally-responsible person identified or others the individual identifies or desires to assist. Person-centered planning focuses on supporting individuals in identifying a vision for their lives. It is a process of building effective and collaborative partnerships with the individual and those working with them to create a road map to reach their vision. A well-written person-centered plan is a rich, meaningful tool that describes the individual's strengths, preferences and, goals. It will identify what services and supports that may be needed to achieve both long and short term goals. It generates positive action steps that the individual, their natural supports and service providers will take towards understanding the goals that are most important and ultimately achieving their vision set forth.

The planning process begins with an assessment of the Individual's current services/placement. It reviews what is important **to** and what is important **for** the individual. The TBI Care Coordinator will assist the individual in scheduling the meeting(s) and inviting those identified to take part. The meeting will be at a time and location that is desired by the individual or their legally responsible person. Each team member receives a written invitation to the meeting. The individual and the TBI Care Coordinator will review with the team any issues that were identified during the assessment process. Information is organized in a way that allows the individual with a TBI to work with the team and have open discussion regarding these or other issues in order to begin planning.

The planning meeting includes a discussion about how often the individual's services, supports and health/safety issues will be monitored. Also during the planning meeting decisions will be made regarding each team member's responsibilities for service implementation and monitoring. The TBI Care Coordinator is responsible for overall monitoring of the ISP and coordination of care with other team members and natural supports. The team members, including the individual, their natural supports/family and other members of the community who are involved in the individual's life, may also be assigned monitoring responsibilities.

A network of contracted community-based service providers will implement the individual's Individual Services Plan by providing the services and supports identified.

Documentation and Waiver Limitations

Documentation is required to access and use NC TBI Waiver services and supports. Alliance is required to assure that NC TBI Waiver funds are used appropriately and in ways that comply with all federal and state regulations. Center for Medicaid and Medicare Services (CMS) 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 TBI Waiver funds cannot be used for services and supports that are not included in the approved 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, CMS and the Department of Health and Human Services (DHHS) – agencies that monitor the use of waiver funding – want to make sure that participants are satisfied with the services and support they receive, and they also want to make sure that those services are helping people make progress with the goals and outcomes in their Individual Support Plans.

Waiver participants, their families, and/or guardians will be asked to participate in some or all of the following quality processes:

- Care Coordination 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 TBI Waiver

NC TBI Waiver operates on a waiver year that runs from May 1-April 30. If you leave NC TBI Waiver services during the waiver year, you can re-enter before the current waiver year ends, provided you continue to meet eligibility requirements.

If you leave NC TBI Waiver services and return after the current waiver year has ended, you may be unable to re-enter right away depending on funding.



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

This section provides an explanation of:

Applying for NC TBI Eligibility

Level of Care Assessment

Support Needs Assessment

Risk Assessment

Prioritization and Registry of Unmet Needs

Applying for NC TBI Waiver Services

A person must first be screened and determined eligible by Alliance in order to receive services and/or to be on the Registry of Unmet Needs for NC TBI Waiver funded services. The process of screening and eligibility determination is started by calling:

Alliance Health
24 Hour Toll-Free Access and Information Line
(800) 510-9132

When you call this number, you will be directed to a qualified TBI Access Coordinator who will work with you to gather the necessary documentation and information to determine potential eligibility for the NC TBI Waiver.

The screening process consists of a comprehensive clinical review that includes an evaluation assessment to complete the NC TBI Level of Care form. If a level of care that meets the waiver is met and a slot is allocated, the TBI Care Coordinator will complete a functional assessment of support needs and a health risk screening. All of these will assist in determining whether the waiver can meet the individual's needs. If health and/or safety risks are identified, an *Alliance TBI Access Coordinator and/or Care Coordinator* will review the assessments and make a determination as to whether the individual's needs can best be met through the TBI Waiver services. Written notification of the outcome of this assessment will be provided to the individual. Individuals determined to be potentially eligible for the waiver are placed on the Registry of Unmet Needs, if waiver funding is **not** available. The TBI Specialist will be available to gather additional documentation if needed and/or make a referral to the network provider of choice for other services/supports that may be available while waiting for the TBI Waiver.

Who is Eligible for NC TBI Waiver Services?

In order to be eligible for NC TBI Waiver services, a person must be:

- Eligible for Medicaid, based on assets and income of the participant.
- A resident of Durham, Wake, Cumberland or Johnston counties (for the purposes of Medicaid eligibility).
- Choosing to participate in NC TBI Waiver services rather than institutional care (hospitals or specialized nursing facilities that have specialized care and services for persons with brain injuries).
- In need of NC TBI Waiver services, as specified in the person-centered Individual Support Plan, and must use at least one NC TBI Waiver service, other than respite, monthly.

AND

- Health, safety, and well-being can be maintained in the community through NC TBI Waiver services within the \$135,000 annual waiver cost limit.

AND

- Live in a private residence or in a licensed facility with six or fewer persons unrelated to the owner of the facility.
- Meet the requirements for eligibility for Skilled Nursing Facilities (SNF) like nursing homes, and/or eligibility for Specialized Hospital Level of Care.
- The consumer must also demonstrate the potential to benefit from specialized rehabilitation and requires specialized brain injury services and/or supports that exceed services available through the SNF eligibility.
- New consumers to this waiver will live with private families or in living arrangements in six beds or less.

What are Skilled Nursing Facilities and Specialty Hospital Level of Care?

A skilled nursing facility is a medical health facility, or a distinct part of a facility that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Individuals eligible for services in an SNF may be eligible for NC TBI services

A specialty hospital level of care for TBI Waiver services is guided by the general criteria for patients with the diagnosis of brain injury with persisting cognitive and behavioral impairments that necessitate 24-hour care and supervision.

Eligibility criteria for SNF and specialty hospital is defined in the Division of Medical Assistance Clinical Coverage Policy on the DHB website at ncdohhs.gov/dma/.

How Is Nursing Facility and Specialty Hospital Level of Care Eligibility Determined?

- If you apply for NC TBI Waiver services, your level of care assessment is completed by a licensed psychologist/psychological associate in our network or your physician (MD). Alliance will make the arrangements for your evaluation, obtain historical assessment information or will send these professionals a form to complete.
- The NC TBI Level of Care Assessment tool is used to determine the initial Level of Care (LOC) for each waiver participant. The TBI Level of Care form integrates information from the FL-2 level of care as well as information appropriate for specialty hospital level of care.
- Once the licensed psychologist, psychological associate, or physician has established eligibility, the Alliance Utilization Management Department authorizes care.
- Each year your level of care is reviewed by your Care Coordinator and a determination is made by Utilization Management about your continued eligibility for the level of care required for participation in NC TBI Waiver.
- Any significant changes in an individual's status may require a reassessment.

Risk/Support Needs Assessment

A risk/support needs assessment is completed by your Care Coordinator. Your Care Coordinator makes sure these risks/needs are addressed in your Individual Support Plan and as needed, in a crisis plan. Potential risks and safety considerations can include health, medical and/or behavioral areas of concern.

Prioritization and Registry of Unmet Needs

If funding is not available for needed TBI services at the time of enrollment and the individual is potentially eligible for the NC TBI 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 TBI 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 wish to leave skilled nursing facilities or specialty hospitals and return to their community using TBI-funded services.

Freedom of Choice

If you choose to apply for NC TBI Waiver services, this means that you are choosing these services rather than placement in an institutional facility (SNF or specialty hospital). You will sign the “Freedom of Choice Statement”, because, as someone who meets the criteria to enter an institutional facility, you are free to choose between either Institutional services or NC TBI Waiver services.

Participant Responsibilities

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

Applying for Medicaid

Medicaid eligibility is a separate issue from eligibility for NC TBI Waiver services. A person can be eligible for Medicaid health insurance and not be eligible for the NC TBI Waiver. 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 TBI Waiver 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 Wake, Durham, Cumberland and Johnston counties can participate in the NC TBI Waiver managed by Alliance.

Things to Know About Medicaid

- If needed, an Alliance representative will assist you in making a Medicaid application. If you already have Medicaid, the Alliance representative can assist you in contacting DSS to let them know that you are applying for NC TBI Waiver services.
- 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. It is important that you keep DSS informed of any changes in your place of residence.
- When an individual applies for Supplemental Security Income (SSI), an application is also made for Medicaid. Individuals apply for SSI at their local Social Security Administration office.
- It is important that you keep your Care Coordinator informed of any address change or change with SSI payments as these changes can affect Medicaid eligibility and as a result, disrupt your NC TBI Waiver services.
- If you plan to move to a county outside Alliance's catchment area, please notify your DSS Medicaid case worker and care coordinator right away so they can assist with coordinating your care to avoid a lapse in services.

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; 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 Coordinator immediately to talk about the possibility of deductible changes).
- Medicaid will not pay for services while an individual is in deductible status.
- For NC TBI Waiver participants, the deductible is calculated over a six-month time period, and is divided into six monthly payment amounts.
- NC TBI Waiver 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 Coordinator can help you plan to meet your deductible each month. You will not receive Medicaid coverage for TBI Waiver services until your Medicaid deductible is met. 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 TBI Waiver 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 (Medicare Part D) requires a co-payment by the Medicaid participant. The indicator in the waiver block in the Medicaid eligibility system alerts the provider agency to any exemption from co-payments that may be waived if you are a NC TBI Waiver participant and do not receive Medicare.

- 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 Coordinator for information about Medicare prescription drug coverage.
- As a NC TBI Waiver 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 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 Coordinator and your provider agency informed of any private insurance or Medicare coverage that you have.

If you do not inform these individuals or 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 TBI Waiver.



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

This section provides an explanation of:

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

Completing the Person-Centered Individual Support Plan

After you have applied for NC TBI Waiver services, completed the assessments, met the eligibility requirements, received an available slot, and been approved for Medicaid, your Care Coordinator 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 Individual Support Plan.
- 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 plan.
- 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 34).
- 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 Supports

When developing your ISP remember that NC TBI Waiver services are 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 everyday life and waiver services are not intended to replace them.

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

NC TBI Waiver 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. NC TBI Waiver services are intended for the individual only and this Medicaid service is not to provide care for other members of the household, such as children or spouses. It is important that you discuss each service you need to use with your Care Coordinator.

Limitations

You may request services that you want to request, in the amount and for the length of time you want to request them provided the service meets the medical necessity requirements. You have due process rights as a TBI Waiver participant to appeal any denials of service requests made by Alliance.

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 TBI Waiver 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 TBI services and equipment, and regular Medicaid services and equipment.
- You or your family cannot pay part of the cost of the service or equipment.
- Providers can neither ask you to sign an agreement that says you will not change provider agencies as a condition of providing services to you, nor require that if the provider agency provides one service, they must be the provider of choice for another one.

Individual vs. Group Services

For services that have a group rate where a potential group exists, the expectation is that the participant receives group services unless there is justification in the member’s ISP that individual services are necessary to meet the disability specific needs of the participant. In

locations such as day programs, you will usually receive group services. If individual services are approved, it is expected that you will change to group services as soon as group services can meet your needs. Your planning team will have to gather additional information to support the request for individual services when you are in a situation where there is a group of other individuals.

Equipment and Supplies

If you need equipment or supplies you should contact your Care Coordinator for assistance. It is important to remember that NC TBI funds cannot pay for equipment or supplies that are covered by your private health insurance, Medicare, or the State Medicaid Plan, even if the private insurance company, Medicare or the State Medicaid Plan (Division of Health Benefits/DHB) deny your request for a covered item or supply. Private insurance companies, Medicare, and the DHB have specific approval processes, providers, and service limitations that must be followed. DHB also has a process to request equipment and supplies that are not on the equipment and supply covered items lists.

Your Care Coordinator can assist you in requesting equipment and supplies from your insurance provider, Medicare or from the Division of Health Benefits (DHB). If a request is denied, your Care Coordinator or Community Guide 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 Coordinator know your needs as soon as possible so that the needed items can be added to your Individual Support Plan and the supporting documentation obtained.

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

The NC TBI Waiver cannot pay for any item obtained prior to approval by Alliance Utilization Management.

If you need an item not covered by your private insurance, Medicaid, or NC TBI Waiver funding, your Care Coordinator can refer you to a Resource Facilitator 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 Coordinator 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 Coordinator to obtain a statement of medical necessity from your physician for the specific equipment or supply recommended.
5. Work with your Care Coordinator to determine the potential source for funding the equipment or supply.

6. Work with your Care Coordinator to submit the request and required documentation for your insurance company, Medicare, Medicaid or NC TBI Waiver.
7. Participate in training to learn to use your new equipment or supply.
8. Keep in close contact with and work with your Care Coordinator to obtain any additional information requested from the funding source of your supply or equipment that is consistent with the NC TBI Waiver service definitions.

Location of Services

In general, NC TBI Waiver 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 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 personal care services 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 TBI Waiver funded services and live in a licensed facility, you may only live in a residential facility that serves six or fewer residents.
- NC TBI Waiver services are not provided in ICF-IID residential facilities.
- New facilities to the NC TBI Waiver may only have a capacity of three beds or less.
- Residential facilities must be licensed by the residential supports provider unless they are serving only one adult as unlicensed Alternative Family Living (AFL).

Qualifications of Staff Providing NC TBI Waiver Services

The NC TBI Waiver identifies provider qualifications for each NC TBI Waiver service. For all services, the direct service employees must be at least 18 years of age and have experience working with individuals with TBI.

Service Definitions

NC TBI Waiver service definitions, including limitations and provider requirements, are included in the waiver. Links to these documents are posted on the Alliance website at [AllianceHealthPlan.org](https://www.alliancehealthplan.org). The information included here is an overview of each NC TBI Waiver service. This section does not include the full service definitions. Your Care Coordinator can also provide additional information about any service you have questions about.

Assistive Technology Equipment and Supplies

Assistive technology equipment and supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain or improve functional capabilities of participants. This service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. The Individual Support Plan clearly indicates a plan for training the participant, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant. A physician's signature certifying medical necessity shall be included with the written request for assistive technology equipment and supplies. Equipment cannot be purchased prior to the item be approved.

Cognitive Rehabilitation

Cognitive rehabilitation is a one on-one therapy, utilized for the development of cognitive (thinking) skills to improve functional abilities including but not limited to: attention, memory, problem solving, and to help identify impaired thinking. The initial goal of therapy is to improve cognitive functioning to the full extent possible. Compensatory strategies will be introduced as progress slows. This phase will assist to achieve an awareness of the ongoing cognitive limitations, maintain skills learned and teach functional strategies necessary to increase the quality of life and enhance their ability to live successfully in the community of their choice. Compensatory strategies also include the training of significant individuals in the person's life. Cognitive Rehabilitation includes a traditional approach which focuses on the individual cognitive impairment and tries to remediate or teach compensatory strategies if restorative objectives are unsuccessful. This approach is most often provided in an office setting. Cognitive rehabilitation also includes a contextual approach that helps individuals achieve their real-world participation in their chosen real-world activities that are blocked by cognitive impairment. This approach is most often provided in the community or in the home.

Community Networking: Service, Class and Conference

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 TBI Waiver 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 should fade. However a formal fading plan is not required.

This service pays for the staff support required to allow maximum participation in the community. The service does cover classes the individual may want to take that offer integration in the community with peers without disabilities.

Community Transition

Community transition is one-time, set-up expenses for adult participants 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, or alternative family living arrangement) to a living arrangement where the participant is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the participant's/legal guardian's/representative's name or a home owned by the individual served.

Crisis Support Services

Crisis support services is a tiered approach to support waiver participants when crisis situations occur that present a threat to the participant's health and safety or the health and safety of others. These behaviors may result in the participant losing his or her home, job, or access to activities and community involvement. Crisis services 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 Individual Support Plan 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.

There are three types of Crisis services that can help you:

- **Primary crisis response:** Trained staff are available to provide "first response" crisis services to waiver participants they support, in the event of a crisis.
- **Crisis behavioral consultation:** Crisis behavioral consultation is available to participants that have intensive, significant, challenging behaviors that have resulted in a crisis situation requiring the development of a crisis support plan.
- **Out-of-home crisis:** Out-of-home crisis is a short-term service for a participant experiencing a crisis and requiring a period of structured support and or/programming. The service takes place in a licensed facility. Out-of-home crisis may be used when a participant cannot be safely supported in the home, due to his or her behavior and implementation of formal behavior interventions have failed to stabilize the behaviors and/or all other approaches to insure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver participants who are unable to access regular respite due to the nature of their behaviors.

Day Supports Individual, Group

Day supports is primarily a group service that provides assistance to the individual with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day

supports are furnished in a non-residential setting, separate from the home or facility where the individual resides. Day supports focus on enabling the individual to attain or maintain his or her maximum functional level and is coordinated with any physical, occupational, or speech therapies listed in the Individual Support Plan. Transportation to/from the individual's home, the day supports facility and travel within the community is included. The cost of transportation to and from the day program is included in the payment rate.

Home Modifications

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. The list of modifications approvable under the TBI Waiver is exhaustive so please have your Care Coordinator review the modifications that are available under the Waiver. 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. 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.

In-Home Intensive Supports

In-home intensive support is available to support participants in their private home, who have exceptional medical or behavioral support needs that are so extensive that the limits on sets of services have been exhausted. Habilitation, support and/or supervision are provided to assist with positioning, intensive medical needs, elopement and/or behaviors that would result in injury to self or other people. Staff implements interventions and assistance as defined in the ISP. The ISP includes an assessment and a fading plan or plan for obtaining assistive technology to reduce the amount of intensive support needed by the beneficiary.

The need for In-home intensive supports is reviewed for re-authorization every 90 days.

Life Skills Training

Life skills training provides rehabilitation and skill building to enable the beneficiary to acquire and maintain skills, which support more independence. Life skills training offers rehabilitative and skill building supports to individuals that live in non-residential settings and are supported in their own home. Life skills training augments the family and natural supports of the beneficiary and consists of an array of services that are required to maintain and assist the beneficiary to live in community settings. Life skills training does not stem from a licensed facility like day supports, nor does it focus on prevocational training. Life skills training consists of:

- Training in interpersonal skills and development and maintenance of personal relationships.
- Skill building to support the beneficiary in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities.
- Training with therapeutic exercises, supervision of self-administration of medication and other services essential to healthcare at home, including transferring, ambulation and use of special mobility devices.
- Transportation to support implementation of life skills training.

Life Skills Training may be provided when a primary caregiver is home.

Natural Supports Education: Individual, Conference

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 traumatic brain injury 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.

Occupational Therapy

Occupational therapy is a treatment and assessment approach that addresses the functional needs of the member related to the effects of the injury on adaptive functioning, adaptive behavior and sensory, motor, posture, perceptual, and/or cognitive abilities. The goal is to assist individuals with TBI to achieve greater independence by regaining physical, perceptual and cognitive skills through exercises and other related activities.

Occupational therapy waiver services are provided when the limits of the approved occupational therapy State plan service are exhausted. Therapeutic treatments provided above the State plan are provided according to the members needs as identified by the licensed provider and keeping with the rehabilitative intent of the waiver.

Personal Care

Personal care services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal care services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene, and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills gained during habilitation while also providing supervision for independent activities. This service may include preparation of meals, but does not include the cost of the meals themselves.

When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the participant, rather than the participant's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices.

Personal care services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider or staff if there is documentation in the ISP that the participant's needs cannot be met in the participant's private home or another community location.

Personal care services do not include medical transportation and may not be provided during medical transportation and medical appointments. Participants, who live in licensed residential facilities, licensed AFL homes, licensed foster homes, or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service or any other State plan Personal care service.

Physical Therapy

Physical therapy is a treatment and assessment approach that addresses the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. Through physical therapy, people with TBI receive treatment to move and perform functional activities in their daily lives and help to prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles.

Physical therapy waiver services are provided when the limits of the approved physical therapy State plan service are exhausted. Therapeutic treatments provided above the State plan are provided according to the members needs as identified by the licensed provider and keeping with the rehabilitative intent of the waiver.

Residential Supports

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

Residential supports 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 three beds or less. Facility capacity for existing residential facilities is six beds.

Residential supports may additionally be provided in an Alternative Family Living 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 more than one adult. All AFL sites will be reviewed using an AFL checklist for health and safety related issues. AFL residential support providers are limited to three beds or less.

Residential supports are provided in licensed residential settings which 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 PIHP through on-going monitoring. Care Coordinators will monitor the home and community character of the group home during Care Coordinator monitoring. Results of the monitoring will be reported to the PIHP and DHB. Providers found out of compliance will be given a timeline in which to come into compliance.

- Care Coordinators continue to offer participants choice of smaller facilities.
- 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.

Resource Facilitation

Resource facilitation promotes the coordination of medical, behavioral, social and unpaid supports to address the beneficiary's needs. Resource Facilitation also informs the planning process with the team and assists beneficiaries with assuring coordinated supports, including direct services. Specific functions include:

- Synthesizing existing assessments and determining needs and risks.
- Coordinating with the medical, behavioral, social and unpaid supports along with the team and the Care Coordination to determine the needed services/supports.
- Working with the beneficiary, the family (as appropriate) and the individual's team as needed to assess, plan, identify, reassess, educate, train, develop resources, and provide emotional support, outreach and advocacy.

Respite

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. It includes transportation from the participant's residence to points of travel in the community.

Specialized Consultative Services

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) to assist family members, support staff and other natural supports in assisting participants with traumatic brain injuries who have long term intervention needs. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan, therefore increasing the effectiveness of the specialized therapy.

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

Speech and Language Therapy

Speech-language therapy is the assessment and treatment of speech and/or language disorders. The assessment and treatment of members with TBI may include language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills, articulation, and conversational skills. It may also address issues related to swallowing and respiration. Speech-language therapy is intended to assist member to regain lost skills and/or achieve a greater level of independence for skills that have permanently changed.

Speech-language therapy waiver services are provided when the limits of the approved speech-language therapy State plan service are exhausted. Therapeutic treatments provided above the State plan are provided according to the members needs as identified by the licensed provider and keeping with the rehabilitative intent of the waiver.

Supported Employment Services

Supported employment services provide assistance with choosing, acquiring, and maintaining a job for TBI Waiver participants for whom competitive employment has not been achieved and /or has been interrupted or has been intermittent. Supported employment services occur in integrated environments with non-disabled individuals or is a business owned by the consumer. Supported employment services do not occur in licensed community day programs.

Initial supported employment services include:

- Pre-job training/education and development activities to prepare a person to engage in meaningful work-related activities which may include career/educational/counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, and assistance in learning skills necessary to retain a job.
- Assisting an individual to develop and operate a micro-enterprise. This assistance consists of:
 - Aiding the individual to identify potential business opportunities.
 - Assistance in the development of a business plan, including identification of potential sources of business financing and other assistance.
 - Identification of the supports that are necessary in order for the individual to operate the business.
- Coaching and employment support activities that enable an individual to complete initial job training or maintain employment such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling.

Long-term follow-up supports include:

- Coaching and employment support activities that enable an individual to maintain employment in a group such as an enclave or mobile crew.
- Ongoing assistance, counseling and guidance for an individual who operates a microenterprise once the business has been launched.
- Assisting the individual to maintain employment through activities such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling.

- Employer consultation with the objective of identifying work-related needs of the individual and proactively engaging in supportive activities to address the problem or need.

Supported employment services include transportation from the participant's residence to and from the job site. The provider agency's payment for transportation from the participant's residence and the participant's job site is authorized service time.

If the individual is employed by the provider the service can continue under the following circumstances:

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

However, if eligible, vocational rehabilitation services should be utilized prior to accessing TBI supported employment services.

Vehicle Modifications

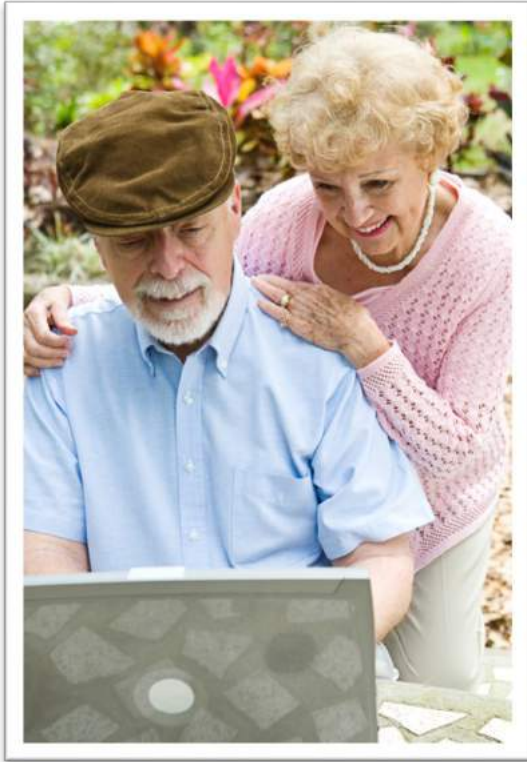
Vehicle modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, and training in the care and use of these items are included. The waiver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

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

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

The requested modification must be prior 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.



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

This section provides an explanation of:

Submitting the Individual Support Plan
to Utilization Management for Approval

Grievances and Appeals

Service Limitations

Utilization Criteria

Service Authorization

Submitting the Individual Support Plan to Utilization Management

The Individual Support Plan belongs to the individual receiving the services. The planning process is person-centered and directed/facilitated by the individual served to the extent they desire. The ISP identifies strengths and capabilities, desires and support needs. When the Individual Support Plan 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. Your Care Coordinator then submits the plan to the 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 Coordinators will review the plan with the individual and/or their legally responsible person before it is signed, answer any questions the individual has, and make any changes to the plan that the individual requests before the individual is asked to sign it. The plan 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 Coordinator submits to Utilization Management includes:

- Contact information for the Care Coordinator.
- 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.
- 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 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 time frame within which that information is due.

Medically-Necessary Treatment

In order for NC TBI Waiver 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 Support Plan which is based upon a comprehensive assessment, and developed in partnership with the person receiving services 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 or several of these medical necessity criteria are, in the professional opinion of the clinicians who make up the Utilization Review (UR) team, not met, it is the responsibility of the UR team to call into question the request for the service or support requested, either because the service is not appropriate, or because the amount or duration of the service requested is not considered appropriate. If any service requested in your ISP is denied, reduced or terminated, you have the right to appeal.

The first step in the appeals process is to request an LME/MCO level appeal. This appeal is a review of the decision that resulted in a denial, reduction or termination of service. Upon receipt of the request, the Alliance Medical Director, or another doctor who was not involved in the original decision, will review the decision as well as information reviewed as part of the initial decision and any new information that is offered. The review may result in Alliance overturning its initial decision, or upholding or modifying its initial decision. A written explanation of the decision and appeal rights are mailed to you or your legal guardian, if applicable. Remember to notify your Care Coordinator and Medicaid case worker at DSS if your mailing address changes.

Your Care Coordinator can help you with any information needed for your appeal. The North Carolina MH/DD/SAS Plan requires that you go through the LME/MCO level appeal process prior to the State fair hearing appeal process. The appeal 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. Appealing a UR decision is your right, and Alliance will never retaliate against you if you choose to appeal.

The Process for Requesting an LME/MCO Level Appeal

- You or your guardian must complete and return the LME/MCO level appeal form to Alliance within **sixty (60) days** from the mailing date of the adverse benefit determination. You may return the form by fax, mail, email, verbally over the telephone or in person. Your provider, a friend or family member can help you, if you give them your permission to do so.

Alliance Health, Attn: Appeals Department
5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560
Phone: (919) 651-8545 or Fax: (919) 651-8682
UMAppeals@AllianceHealthPlan.org

- Oral requests must be followed up in writing with a signed written request for appeal within sixty (60) days of the mailing date of the adverse benefit determination, unless it is a request for an expedited resolution.
- Alliance will provide reasonable assistance with filing an appeal request.
- Alliance will send you a letter acknowledging receipt of the appeal request.
- You may ask to review any information used in the LME/MCO level appeal process.
- You may also submit any additional information you feel supports your request for Medicaid services.
- Services may be continued during the review under certain circumstances as defined below.
- Alliance is to issue a written decision no later than thirty (30) days from receipt of the request, except that pursuant to federal law Alliance can extend the timeframe for up to fourteen (14) days if you request the extension or Alliance shows there is a need for additional information and that the delay is in your best interest.

What if I Disagree with the LME/MCO Level Appeal Decision?

If you disagree with a Medicaid decision you may appeal that decision to the North Carolina Office of Administrative Hearings. State-funded service decisions go to a panel at DMH/DD/SAS and cannot be appealed to OAH. A form and instructions to start the appeals process will be enclosed with the LME/MCO level appeal review decision.

What is the OAH Appeals (Medicaid State Fair Hearing) Process?

- You must file your appeal with the North Carolina Office of Administrative Hearings within 120 days of the mailing date of the notice of resolution. You may represent yourself in this process or you may retain an attorney. Alliance can provide assistance in filing an OAH appeal.
- After you file your appeal, you will be offered the opportunity to have your case mediated.
- If you accept mediation, it must be completed within 25 days of your request.
- If you decline mediation, or if mediation is unsuccessful, your appeal will proceed to a hearing.
- After the hearing, an administrative law judge will make a decision regarding your case.
- If you disagree with the administrative law judge's decision, you may appeal your case to Superior Court.

To learn more about the appeals process, call the North Carolina Office of Administrative Hearings at (919) 431-3000 or call the Alliance 24 hour toll-free number at (800) 510-9132.

Will my Services be Authorized During the LME/MCO Level Appeal Process?

Alliance is required to continue the member's benefits (services) during the LME/MCO level appeal if all of the following conditions are met:

- The appeal was filed within ten days of Alliance mailing the adverse benefit determination, and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired, and
- The member specifically requests continuation of benefits.

Services must be continued while the appeal is pending until any one of following occurs:

- The member withdraws the appeal, or
- Ten days pass after Alliance mails the notice of appeal resolution, unless the member has requested a State fair hearing within those ten days, or
- The Office of Administrative Hearings issues a hearing decision adverse to the member, or
- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal upholds the Alliance decision, Alliance may recover the cost of the services furnished to the member while the appeal was pending. Alliance may only seek recovery from the member, the spouse of an adult member, or the parent or legal guardian of a minor member. A decision about whether to seek to recover the cost of such services shall be made by the Alliance CEO or designee, taking into account the following factors:

- The financial ability of the member to reimburse Alliance; and
- The costs to Alliance of recovering such funds; and
- Whether the appeal had no merit, was frivolous, or was not filed in good faith.

What if I Need Legal Assistance?

To locate a lawyer please call (800) 662-7660 for the North Carolina Health Information Project Lawyer Referral Service or (800) 662-7407 for the North Carolina State Bar Lawyer Referral Service. You can also call Disability Rights of North Carolina toll-free at (877) 235-4210 or Legal Aid of North Carolina at (866) 219-5262.

Service Limitations

Limits on sets of services (services provided in combination) are intended to be the maximum amounts of services an individual with exceptional disability needs can receive. Limits on sets of services apply to the following NC TBI Waiver services, per plan year and are subject to change with each waiver renewal:

- Community networking services
- Day supports
- Life skills training
- Personal care
- Supported employment.

Other Types of Limitations

Each service definition has additional limitations that are listed in the approved waiver. Your Care Coordinator 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 have spending limits per year or over the duration of the NC TBI Waiver (3 years).
- Services that cannot be provided in certain locations.
- Services that have other conditions on their use.

Utilization Criteria

Alliance is allowed by contract with NC Medicaid 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 Coordinator or someone from the Utilization Management Department will assist you.

Utilization Management Care Managers will review the information submitted by your Care Coordinator 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.

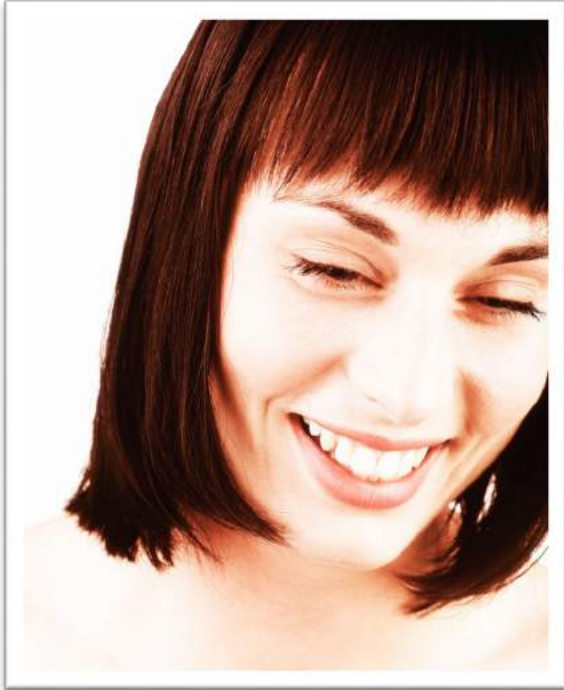
As a result of that review, the Utilization Management Care Manager will approve the authorization for the services requested or refer for higher level review. Decisions to reduce or deny a request for authorization of a service can only be made by an Alliance licensed psychologist or medical doctor. Denials or reductions in services can be appealed (see Appeal Rights).

Service Authorization

All NC TBI Waiver services must be approved in the Individual Support Plan and authorized to allow the provider agency to bill Alliance. ISP approval and authorization is completed by the Utilization Management staff, called Care Managers.

You will receive a copy of your ISP and the approval letter from your Care Coordinator 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 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 provides an explanation of:
Alliance Health's Provider Network
Starting Your Services

Alliance Health's 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 TBI Waiver. 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 all the Alliance network providers.

Provider Responsibilities

- Participating in Individual Support Plan and other service planning meetings with you, your Care Coordinator 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 Coordinator 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.
- Completing quarterly progress summaries for habilitation services.

Selecting Service Providers

During the development of your Individual Support Plan, you need to decide which network providers best meet your needs. Your Care Coordinator 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?
- Who 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 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 or someone of my choosing to notify me of the home visit?

Starting Your Services

Implementation of the ISP is a shared responsibility for 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 Coordinator 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 TBI Waiver indicator can be placed on your Medicaid record.



Section 6: NC TBI Waiver Policies and Procedures

This section provides an explanation of:

Monitoring of Services by the Care Coordinator

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

Traveling Out of State

Other Helpful Information

Monitoring of Services by the Care Coordinator

Your Care Coordinator is responsible for monitoring the implementation of your Individual Support Plan 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 sure 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 sure 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 Coordinator Occur?

- If you are new to the waiver, you will receive monthly face-to-face visits for the first six months and then as scheduled in your individual service plan, but no less than quarterly.
- If you live in a residential program, 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 as scheduled in your plan, but no less than quarterly.
- If you do not receive a face-to-face visit during the month, your Care Coordinator will have contact with you by telephone.

Minimum Use of Services Required to Remain on NC TBI Waiver

The NC TBI Waiver requires individuals to use one waiver service that is included in their Individual Support Plan (other than respite) each month to remain eligible for the waiver. If you do not use a waiver service each month, you will be notified by Care Coordination. 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 (DHB) prior to terminating a

NC TBI Waiver participant for non-use of waiver services. Anyone terminated from NC TBI Waiver 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 Coordinator or UM Care Manager know if you have questions.

If you are removed from NC TBI Waiver due to non-use of services, you may request to re-enter NC TBI Waiver 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 TBI “waiver year” runs from May 1 to April 30.

Services Provided Outside North Carolina

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

- Services for members who have been receiving services from direct care staff while in state and who are unable to travel without their assistance.
- Members who live in alternative family living homes may receive services when traveling with their alternative family living home family out-of-state under these guidelines.
- Members 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 member’s cost of care does not increase.
- Written prior approval of this request for their staff to accompany an individual served and their family out- of-state must be received from the supervisor of the staff person and Alliance, 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 members 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 and board, nor transportation costs of the member, family or staff.
- Provider agencies and Agencies With Choice assume all liability for their staff when out of state.

Other Helpful Information

Absences, Relocations and Terminations

If you are absent from NC TBI Waiver services, your Care Coordinator may need to take certain actions. The action needed depends on the nature of the absence. If you are hospitalized, placed in a 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 Coordinator about continuing Medicaid eligibility. You should keep your Care Coordinator informed of all absences or anytime you are admitted to a hospital or institution.

Transferring TBI Waiver Services

NC TBI Waiver participants are currently legal residents (for the purpose of Medicaid eligibility) of the Alliance catchment area, which includes the following counties: Wake, Durham, Cumberland, and Johnston. 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 TBI Waiver. Your Care Coordinator works with you in transferring services to the LME/MCO that you are moving to and terminates you from Alliance's NC TBI Waiver. The Care Coordinator provides the receiving LME/MCO with all requested information needed with your written consent. Currently the NC TBI Waiver is only available in the Alliance LME/MCO geographic area.

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 that services can be approved in your new county of residence. It will take a few weeks or even a month or more for the Medicaid to transfer. Your Alliance Care Coordinator will assist in linking you to available services and resources to support you in your transition.

Terminations from NC TBI Waiver

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

- Department of Social Services terminates Medicaid eligibility.
- The person-centered Individual Support Plan is not approved, (which can be appealed).
- Placement in a skilled nursing or specialty hospital 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.
- No longer meet SNF or specialty hospital level of care as determined by Utilization Management (which can be appealed).

When terminations from NC TBI Waiver are necessary:

- Appeal rights are provided to the individual or legal guardian in writing by the agency terminating them from NC TBI Waiver 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 Coordinator 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-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 dismissed from receiving services or are not enrolled in the NC TBI Waiver you may ask your Care Coordinator 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 TBI Waiver. DSS will inform you if you will continue to have Medicaid coverage.

Suggestions for Improvement to NC TBI Waiver

Your suggestions about ways to improve the NC TBI Waiver are always welcome. Some operational procedures can be changed by Alliance, while others require the approval of the State or Center for Medicare & Medicaid Services (CMS). Please talk with your Care Coordinator 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 TBI Waiver 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)

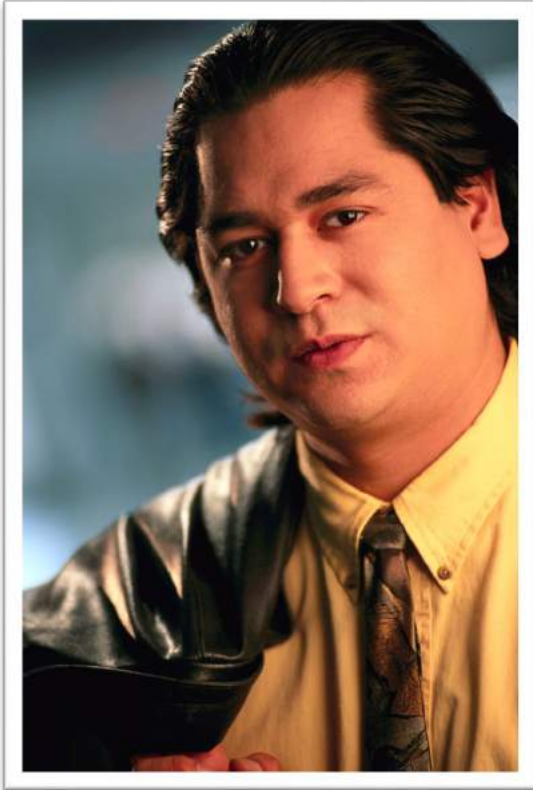
The Consumer and Family Advisory Committee membership consists of consumers and family members who receive mental health, intellectual/developmental disabilities and substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to

Alliance administration and the Alliance Board of Directors. If you would like to share more feedback on the TBI Waiver, please consider joining your local CFAC group.

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/other developmental disabilities and substance use/addiction services.

For more information, call toll-free at (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 provides a list of acronyms and an explanation of words and terms used throughout this Guide

Acronyms in the Guide

ABI	Acquired Brain Injury
AFL	Alternative Family Living
CAP	Community Alternative Program
CMS	Centers for Medicare & Medicaid Services
DHHS	Department of Health and Human Services
DHB	Division of Health Benefits
DSS	Department of Social Services
HCBS	Home and Community Based Services
ICF or ICF-IID	Intermediate Care Facility (for Individuals with Intellectual Disabilities)
ID or I/DD	Intellectual Disability or Intellectual/Developmental Disability
IDEA	Individuals with Disabilities Education Act
ISP	Individual Support Plan
LME/MCO	Local Management Entity/Managed Care Organization
MD	Medical Doctor or Physician
MFP	Money Follows the Person
MH/DD/SA	Division of Mental Health, Developmental Disability, Substance Abuse
PIHP	Prepaid Inpatient Health Plan
QP	Qualified Professional
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	(Social Security) Supplemental Security Income
TBI	Traumatic Brain Injury
UM	Utilization Management

Glossary of Words and Terms to Know

Alliance Health: A multi-county Managed Care Organization (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 Durham, Wake, Cumberland and Johnston 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.

Care Coordinator: A qualified professional at Alliance who assists members with their person-centered Individual Support Plan (ISP), coordinating services, and monitoring to assure quality services are being delivered and that health and safety needs are addressed.

Care Manager: Care Managers conduct utilization management (authorization of services), 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.

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: For NC TBI Waiver 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 North Carolina Medicaid and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. The North Carolina DHHS website is ncdhhs.gov.

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

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, NC TBI Waiver, and NC MH/DD/SAS Health Plan. The website for North Carolina's DMH/DD/SAS is ncdhhs.gov/assistance/disability-services/traumatic-brain-injury.

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 TBI Waiver is one of North Carolina's HCBS waivers.

Health Risk Screening: An assessment to screen for health risks connected with a variety of disabilities that may affect the human body and the person's ability to engage in functional activities (e.g., developmental disabilities, physical disabilities, disabilities associated with age).

In-Home Services: In NC TBI Waiver this includes in-home intensive support, respite and personal care.

Institution: For purposes of NC TBI Waiver, an institution is defined as a residential facility that is licensed and funded as a skilled nursing facility. NC TBI Waiver funding cannot be used in an institution, including ICFs-MR, hospitals, skilled nursing facilities, or State Developmental Centers.

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 (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.

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 TBI Waiver services are provided under the Medicaid program. All NC TBI Waiver participants have Medicaid coverage.

Medically-Necessary Treatment: In order for NC TBI Waiver 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 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 TBI Waiver services are not provided under the Medicare program, some individuals enrolled in the NC TBI Waiver may have Medicare coverage in addition to Medicaid coverage.

Most Integrated Environment: The least restrictive setting of care sufficient to effectively support an individual. An integrated environment is one in which a person with a disability participates in the same activities and settings as non-disabled individuals.

NC TBI Waiver Level of Care: The document used for determining what the minimum amount of assistance an individual may require in order to receive services in an institutional setting under the State Medicaid Plan. For the NC TBI Waiver the institutional level of care setting that corresponds to the level of care that must be met for NC TBI Waiver is the skilled nursing facility or specialty hospital level of care.

NC TBI Waiver: The NC TBI Waiver is a means of funding services and supports for individuals with traumatic brain injury who are at risk for institutional care in a skilled nursing facility or specialty hospital but who chose instead to remain in their own home and community. NC TBI 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 Medicaid 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 the Durham, Wake, Cumberland and Johnston counties.

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

The Division of Health Benefits (DHB), the State Medicaid agency, operates the NC TBI 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 TBI Waiver, approves all policies and procedures governing waiver operations and ensures that the NC TBI 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, spouses, siblings, children, extended family members, neighbors, church members, and/or co-workers, etc.

Neurobehavioral Center: An inpatient facility program for adults who have sustained an acquired brain injury (ABI) and have struggled in society due to problems managing their behavior effectively.

Participant/Individual/Member: The person who is approved to receive services under the NC TBI 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 Managed Care Organizations (MCOs), functions as a Prepaid Inpatient Health Plan through which all mental health, substance abuse and developmental disabilities services are managed and authorized for Medicaid participants in the Durham, Wake, Cumberland, and Johnston 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 spouses, 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 TBI Waiver funding for identified needs.

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

Service Limit: The maximum amount of a specific services that can be received under certain NC TBI Waiver services.

Skilled Nursing Facility (SNF): A service which are furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Records Management and Documentation Manual (RM and DM): 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/distribution of the number of individuals to be served through the Waiver. The Center for Medicare and Medicaid Services (CMS) allows North Carolina to serve a given number of individuals on NC TBI each waiver calendar year. This number is the number of “slots” available for that year.

State Plan: The term that refers to the State Medicaid Plan for Medicaid for the State of North Carolina that is approved by CMS.

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

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 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 TBI Waiver this is May 1 to April 30.

Appendix A

Participant Responsibilities for NC TBI Waiver

(Insert name of PIHP)

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

Client:

Record Number:

PARTICIPANT RESPONSIBILITIES

I understand that enrollment in the North Carolina (NC) TBI Waiver is voluntary.

I also understand that if enrolled I will be receiving Waiver services instead of services in a Skilled Nursing Facility or Specialty Hospital for Individuals with traumatic brain injury. My Medicaid eligibility must continue to come from a county in a North Carolina TBI Waiver area for me to continue to be eligible for the NC TBI Waiver and I must continue to meet all other waiver eligibility criteria.

- I understand that by accepting NC TBI Waiver funding that I am in need of waiver services to prevent an immediate need for Skilled Nursing Facility or Specialty Hospital services.
- I understand that to maintain my eligibility for this waiver I must receive **at least one waiver service monthly** and that failure to use a waiver service monthly will jeopardize my continued eligibility for the NC TBI Waiver. The services approved in my Individual Support Plan have been determined necessary to improve/support my disability.
- I understand that as a participant in the NC TBI Waiver I may live in a private home or in a residential facility licensed for 6 or fewer beds **and** if living in a facility the facility must meet the home and community based service characteristics defined in the waiver. If I am currently a participant in NC TBI Waiver or am transitioning to the NC TBI Waiver from other services, my Care Coordinator has explained to me how these requirements apply to my current living arrangement.
- I understand if I choose to move to a facility during my participation in the waiver, that if it is larger than 6 beds or does not meet the home and community characteristics defined in the waiver, I will no longer be eligible for the waiver.
- I understand that the total of my waiver services cannot exceed \$135,000 when I enter the waiver.
- I understand that at any time during my plan year, the total of my waiver services cannot exceed \$135,000 or I will no longer be eligible for the waiver.
- I understand if I select the NC TBI Waiver, that I will have an Individual Support Plan (ISP) developed that reflects services to meet my needs. My Care Coordinator will explain the planning process and the establishment of my Individual Budget to me.

- My ISP will be re-developed annually prior to my birth month. I understand the NC TBI Waiver will deliver services according to my ISP.
- I understand that I may be required to pay a monthly Medicaid deductible if that is part of my financial eligibility for waiver services. My Care Coordinator can assist me in obtaining information on Medicaid deductibles from my local Department of Social Services.
- I understand that I will cooperate in the assessment process to include but not be limited to a NC TBI Waiver Assessment tool, NC TBI Risk/Support Needs Assessment, and a Level of Care eligibility evaluation.
- I understand that my ISP will be monitored and reviewed by my Care Coordinator, and that I can contact my Care Coordinator at any time if I have questions about my ISP, Individual Budget or the services that I receive.
- I understand that I have the right to choose a provider within the Alliance Provider Network.
- I understand that I am required to meet with my Care Coordinator for care coordination activities in my home or wherever my family member lives and/or settings where services are provided to allow my Care Coordinator access to all settings where services are provided. The Care Coordinator will schedule meetings as often as needed in order to ensure appropriate service implementation and participant's needs are met. I may also request meetings.
- I understand that I am required to notify the Care Coordinator of any concerns regarding services provided.
- I understand that I am required to give adequate notice to the Care Coordinator of any change in address, phone number, insurance status, and/or financial situation prior to or immediately following the change.
- I understand that I am required to give adequate notice to the Care Coordinator of any behavior or medication changes as well as any change in health condition.
- I understand that I am required to attend appointments set by the Department of Social Services (DSS) to determine Medicaid renewals to ensure my continued Medicaid eligibility.
- I understand that I will be provided a copy of educational information about the NC TBI Waiver to assist with my understanding of the services available through this Waiver along with what guidelines need to be followed to ensure continued eligibility.
- I understand that Alliance Health is responsible for ensuring an adequate network of provider agencies is available to promote choice.
- I understand that Alliance Health will make a Care Coordinator available to provide care coordination supports which include:
 1. An assessment to determine service needs to include but not be limited to a NC TBI Waiver Risk and Support Needs Assessment.
 2. Working with the Individual Support Planning Team to coordinate and document the Individual Support Plan (ISP).
 3. Requesting any and all services under the TBI Waiver as listed in the ISP.

4. Informing the participants of the amount of their Individual Budget, the process used to establish their budget and make any needed changes.
5. Monitoring all authorized services to ensure they are provided as described in the ISP and meet the participant's needs.
6. Assisting the participant with the coordination of benefits through Medicaid and other sources to include, if needed, linkage with the local Department of Social Services regarding coordination of Medicaid deductibles.
7. Responding to any complaints or concerns and reach resolution within 30 days of the complaint regarding NC TBI Waiver services.
8. Promoting the empowerment of the participant to lead as much of his/ her Individual Support Planning, decision making regarding the use of waiver dollars/their budget and oversight of waiver services choose.
9. Obtaining an order from the participant's physician for needed medical supplies, specialized equipment and/or any service needs that require such.
10. Supporting the participant in obtaining all needed information to make an informed choice of provider within the Alliance Health network, inclusive of notifying the Alliance Network Management Department if providers are needed outside of the current Alliance Network.

Name of Participant

Date

Signature of Participant
(or Authorized Representative)

Date

Appendix B

NC TBI Waiver Limits on Sets of Service

Participant Level of Care	Living in Residential Setting	Living in Private Home
Nursing Facility	<p>No more than 30 hours/week for any combination of services below:</p> <ul style="list-style-type: none"> • Community Networking • Adult Day Health • Day Supports • Supported Employment Services <p>May receive up to one(1) unit of Residential Supports daily</p>	<p>No more than 49 hours/week is authorized for any combination of the services below:</p> <ul style="list-style-type: none"> • Community Networking • Adult Day Health • Day Supports • Supported Employment Services • Personal Care • Life Skills Training
Specialty Hospital/ Neuro-Behavioral	<p>No more than 40 hours/week for any combination of services below:</p> <ul style="list-style-type: none"> • Community Networking • Adult Day Health • Day Supports • Supported Employment Services <p>May receive up to one(1) unit of Residential Supports daily</p>	<p>No more than 84 hours/week is authorized for any combination of the services below:</p> <ul style="list-style-type: none"> • Community Networking • Adult Day Health • Day Supports • Supported Employment Services • Personal Care • Life Skills Training

Services Not Subject to Limits on Sets of Services

Additional Services	<ul style="list-style-type: none"> • Assistive Technology Equipment/Supplies • Cognitive Rehabilitation • Community Transition Services • Crisis Services • Natural Supports Education • Resource Facilitation • Specialized Consultative Services 	<ul style="list-style-type: none"> • Assistive Technology Equipment/Supplies • Cognitive Rehabilitation • Crisis Services • Home Modifications • Natural Supports Education • Resource Facilitation • Specialized Consultative Services • Vehicle Modifications
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Record of Review and Revisions

DATE	PAGE/SECTION	DESCRIPTION
October 2016, May 2017	Entire Document	CFAC, DMA, Interdepartmental Review
July 2018; August/September 2018	Entire Document	CFAC, DMA, Interdepartmental Review