December 2023

NC Innovations

Individual and Family Directed Supports Handbook

Alliance Health

BKT988041E02

Self-Direction Manual Revisions (posted December 2023)

Handbook Reference and Page Number	What Changed
Page 19: Payments may not be made directly to the individual, the EOR, the representative, or family. Instead, only the person (individual or entity) providing the service, supply or other item receives the payment.	This section is removed and should not have been included in the August 2022 revision to the Individual and Family Directed Supports Handbook. Financial Support Service agencies should follow Clinical Coverage Policy 8-P which includes ordering employment related supplies and paying invoices for other expenses.
Page 19: Funds that have not been used by the first of the month that occurs four months after the end of the individual's plan year will be recovered by Alliance from FSA.	Effective October 1, 2023, Alliance has waived this requirement due to the transitions from GTI while the reconciliation process is still underway.
Page 19: Bonus payments to employees are limited to $5,000 per employee every 12 months.	Effective October 1, 2023, Alliance has waived this limit due to the transitions from GTI while the reconciliation process is still underway.

Introduction to Individual and Family Directed Supports

The North Carolina Innovations Waiver gives people with disabilities clear choice about how they receive services. The Innovations Waiver offers individuals both agency-directed and individual-directed supports options. Services directed by individuals on the waiver are known as Individual and Family Directed Services (IFDS).

Self-Determination

The individual and family directed supports option is based on the concept of self-determination, also sometimes referred to as self-direction. Self-determination is a process that supports the person in designing and exercising control over their own life and directs a set amount of dollars that will be spent on authorized supports and services, often referred to as an "individual budget."

The Principles of Self-Determination

Self-determination is a process that is built upon these 5 principles:

- **Freedom** – To decide how one wants to live their life.
- **Authority** – To control a targeted amount of dollars.
- **Support** – To organize resources in ways that are life enhancing and meaningful to the individual.
- **Responsibility** – The recognition of the contribution individuals with disabilities can make in their communities, as well as accountability for spending public dollars responsibly.
- **Confirmation** – The recognition of the importance of the leadership of self-advocates in the self-determination movement.

Benefits of IFDS

- Increased independence and self-sufficiency
- Increased choice, flexibility, and control of services
- Improved quality of services
- Increased opportunities for a more healthy, productive life with better personal outcomes
- Increased satisfaction with services
- Increased use of people the individual knows as employees
- Expanded information to assist in decisions around spending of resources
- Focused assistance to make Individual and family direction possible
- Authority to hire, train, supervise and fire employees
- Increased partnership between individuals, families and professionals
- Increased meaningful relationships in the community

IFDS Options

The Innovations Waiver offers two options for self-direction of waiver services to individuals and families:

Agency with Choice (AWC)

The agency with choice model allows the individual or their legally responsible person to work with an agency that agrees to hire employees referred by them. The agency approves and disapproves the hiring of the referred employees and ultimately retains the responsibility of being the employer while allowing the individual or legally responsible person to partner in managing the employee's training and supervision. The individual or the legally responsible is known as the managing employer.

Employer of Record (EOR)

The employer of record model allows the individual or their legally responsible person to be the individual who can legally exercise authority over employees and assume the other responsibilities associated with the individual and family direction of services. The individual or the legally responsible person is known as the employer of record.

Services That May be Self-Directed

All individuals on the waiver are offered the opportunity to direct one or more of the following services:

- Community living and supports
- Community networking
- Individual goods and services (in conjunction with at least one other self-directed service)
- Natural supports education
- Respite
- Supported employment
- Supported living

An individual, their family, or their legally responsible person may elect to direct as many or as few of the listed services as they choose. All hours of any chosen service must be self-directed.

Who's Who in Self-Direction

Agency with Choice (AWC model)

Agency with choice (AWC) providers work with the managing employer to manage employees. AWC providers will also assist with other responsibilities of directing services. The AWC provider serves as the common law employer with federal and state agencies for employees hired to provide the services in the individual support plan (ISP). AWC providers perform the financial functions for the managing employer in the agency with choice AWC model. The cost of these activities is built into the service rate for the direct services billed by the AWC provider. Examples of some AWC provider tasks include:

- Processing employees' paychecks
- Deducting required taxes
- Maintaining worker's compensation insurance
- At least monthly, the managing employer and representative, if applicable, will receive a budget report from the agency with choice

Care Manager

The care manager is employed by Alliance Health and provides support to individuals who participate in the IFDS option. The care manager responsibilities include:

- Provide orientation to the IFDS option per the *Medicaid and Health Choice Clinical Coverage Policy No: 8-P*
- Provide the prospective employer with a list of community navigator providers for IFDS training
- Assist LRP to identify a person to act as managing employer and discuss potential need for a representative
- Complete referral to provider for community navigator training for EOR
- Complete ISP update for community navigator training for EOR
- Request additional authorization of community navigator training for EOR if needed
- Provide the individual a list of AWC support providers
- Provide any assistance needed to the prospective employer in selecting a financial support agency contracted with Alliance
- Complete and submit a referral to identified service provider for AWC or FSA for EOR
- Complete ISP update to transfer self-directed services to provider and to document request for financial support services, EOR supplies, and on-going community navigator service
- Submit for Utilization Management (UM) review and approval to begin individual and family directed services

Community Navigator

This service supports individuals, representatives and employers of record or managing employers who direct their services by providing direct assistance in their self-direction responsibilities. Community navigator services are intermittent and may fade as community connections develop and skills increase in individual and family direction. The community navigator will be mandated until the employer of record can demonstrate competency in all employer functions. If the individual is self-directing their services, the community navigator functions will include:

- Provide initial training on the individual and family directed supports options, if the individual is considering directing services and supports
- Coordinate services with the financial support services (FSS) provider (the financial support agency (FSA)) such as guidance on use of the individual and family directed budget (EOR model)
- Coordinate services with the agency with choice (AWC model)
- Provide information/coaching/technical assistance on recruiting, hiring, managing, training, evaluating and changing support staff (AWC and EOR models)
- Provide information/coaching/technical assistance with the development of schedules and outlining staff duties (AWC and EOR models)
- Provide information/coaching/technical assistance on maintenance of records in accordance with the employer of record model (EOR model)
- Provide information/technical assistance to the individual on setting staff schedules

- Provide ongoing training on documentation requirements, monitoring of services, labor laws, clinical coverage policy requirements and all pertinent information required for service delivery
- Provide guidance with management of the individual and family directed budget
- Provide information on recruiting, hiring, managing, training, evaluating and changing support staff
- Assist with the development of schedules and outlining staff duties
- Assist with understanding staff financial forms, qualifications and record keeping requirements (AWC and EOR models)
- Provide ongoing information to assure that individuals and their families/representatives understand the responsibilities involved with the individual and family direction, including reporting on expenditures and other relevant information and training

The community navigator also provides the managing employer, EOR or representative with a copy of an employer handbook and other training materials. The training and educational materials provide sufficient information to ensure that the individual and/or legally responsible person make informed choices about the degree wich they wish to self-direct services.

Care Worker

The care worker is employed by Alliance and collaborates with the employer, FSA and community navigator to monitor and support engagement in services. The care worker will:

- Monitor status of IFDS training sessions with the community navigator
- Review training progress with assigned agency representative
- Obtain IFDS training certificate from community navigator
- For EOR, assess the EOR's or representative's IFDS competency by completing the IFDS assessment
- For EOR, complete IFDS agreement with the EOR or representative. The agreement is developed by Alliance
- For EOR, assist managing employer or appointed representative to complete and submit signed EOR agreement, EOR managing employer assessment, and EOR training certificate to the Provider Network department at enrollment@AllianceHealthPlan.org for review, routing, and approval prior to the ISP update to implement EOR services
- Provide a copy of the approved ISP or update to the ISP to the community navigator and employer of record
- Complete monthly IFDS monitoring including:
    - Employer-related responsibilities are fulfilled
    - Service is being utilized as authorized
    - Employer has all necessary employment supplies, if applicable
    - Individual and/or family are satisfied with services and progress
    - Monthly financial reports are reviewed

- Approved services meet identified needs and maintain health and safety
- Emergency plans and back-up staffing is in place
- Incident reporting is completed
- Service documentation and timesheets are maintained

Individual

The individual is the person approved to receive services under the NC Innovations Waiver. The individual may or may not be the employer of record. If the individual is not the employer of record, the ISP will include a statement of how the individual will be involved in self-directing services.

Employee in EOR model

All prospective new employees in the EOR model will have criminal background checks, driver's license checks and health care registry checks. Employees in the EOR model will:

- Be at least 18 years of age
- Have a valid North Carolina driver's license or other valid driver's license and a safe driving record, and an acceptable level of automobile liability insurance, if providing transportation
- Not be listed in the North Carolina Health Care Abuse Registry
- Become qualified in CPR and First Aid
- Become qualified in the customized needs of the beneficiary as described in the ISP
- Have a high school diploma or high school equivalency (GED)
- Be absent of a history of abuse, neglect, exploitation or violent crimes against children or vulnerable adults
- Have a criminal background check that presents no health and safety risk to beneficiary

The following convictions result in a lifetime ban on employment:

- Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance
- Felony health care fraud
- More than 1 felony conviction
- Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult
- Felony or misdemeanor patient abuse
- Felony or misdemeanor for abuse, neglect or exploitation of a minor or disabled adult
- Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry and
- Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC

The FSA will assist with reviewing the background check to ensure the prospective new employee does not have any convictions on the convictions barring employment list. If the employee has a conviction listed in

§108C-4 but not on the convictions barring employment list, the EOR may elect to hire the employee if the EOR feels the employee can perform the duties of their job while also maintaining the beneficiary's health and safety. The EOR must complete the FSA background check acknowledgement form and maintain a copy of the FSA background check acknowledgement form in the staff's personnel file. The EOR must notify the LME/MCO that they have hired a staff that required completion of the background check acknowledgement form.

Employers of record and managing employers participating in the individual and family directed option may not be employed to provide waiver services. Employer of record and agency with choice in conjunction with the managing employer must monitor the relative or legal guardian's provision of the service on site and at a minimum of one time per month.

Employer of Record (EOR model)

An adult on the Innovations Waiver, parent(s) of a minor on the Innovations Waiver, or legal guardian is considered the employer of record (common law employer). He or she must be at least 18 years old. The employer of record may not be an LLC and may not provide paid supports to the individual.

The employer of record is responsible for all aspects of managing the employees, including ensuring that services are provided as outlined in the ISP.

The employer of record will:

- Complete IFDS training with a community navigator
- Involve the individual as outlined in the ISP and provide services as written in the ISP and defined in NC Innovations services
- Collaborate with FSA and employees in the completion of hiring packages
- Assist employees in reporting on-the-job injuries to the FSA
- Decide which special skills and training employees need
- Work with the FSA to assure that employees are trained per Innovations and ISP requirements
- Communicate clearly and openly with the care manager, care worker, FSA, community navigator and employees
- Give direction and feedback to employees and complete time sheets as required by FSA
- Comply with all applicable employment laws
- Review monthly reports from the FSA and community navigator
- Utilize services as written in ISP
- Ensure that the Individual's health and safety are not at immediate risk
- Participate in the development of the ISP and make decisions about the best way to meet the needs of the Individual, including the responsible use of the individual and family directed supports budget
- Develop reliable back-up plans for coverage when employees are absent and emergency situations
- Notify the care manager if the ISP needs to be changed
- Complete incident reports as needed
- Dismiss employees when necessary

- Participate in evaluating the effectiveness of services and inform the care manager of difficulties encountered
- Notify the care manager of admission to a hospital, intermediate care facility (group home or developmental center), or other facility
- Accept the decision of Alliance regarding the need for a representative and/or community navigator services
- Meet their monthly Medicaid spend down (deductible) if it determined by DSS that this is required for Medicaid eligibility
- Develop short range goals and task analysis/strategies for achieving long range ISP outcomes and maintain service documentation

Financial Support Agency

The FSA provides the waiver service called financial support services (FSS). FSAs are utilized by employers of record for paying employees and ensuring that other fiscal functions are completed. FSS is a required service for individuals who choose the IFDS employer of record model. The cost of FSS is paid out of the individual budget as an add-on to that budget.

The financial support agency will provide the following functions:

- Managing all payroll functions
- Assuring that individual and family directed funds outlined in the ISP are managed and distributed as intended
- Filing claims for self-directed services and supports
- Ensuring that Electronic Visit Verification (EVV) requirements are met for applicable services
- Providing EVV platform for the employee/employer to schedule and record staff shifts when applicable to the service required
- Payment of payroll to employees hired to provide services and supports
- Deducting all required federal, state, and local taxes, including unemployment fees, prior to issuing paychecks to employees
- Ordering employment related supplies and paying invoices for other expenses such as training of employees
- Administering benefits for employees hired to provide services and supports
- Maintaining accounts for each individual's funds, including claims paid, expenses and accrued funds
- Tracking and monitoring individual budget expenditures
- Producing expenditure reports that are required, including reports to the individual/employer/family concerning expenditures of funds against their budgets
- Requesting criminal background checks, driver's license checks, and health care registry checks of providers of self-directed services
- Purchasing individual goods and services on behalf of the individual
- Facilitating workers compensation application on behalf of the employer of record
- Serving as the Internal Revenue-approved fiscal employer agent

Managing Employer

An adult on the Innovations Waiver, parent(s) of a minor on the Innovations Waiver, or legal guardian is considered the managing employer or co-employer in the IFDS agency with choice model. The managing employer must be at least 18 years old. Parent(s) of a minor child who is on the waiver can be the managing employer. The managing employer may not provide paid supports to the individual.

The managing employer will:

- Assist the agency with choice and employees in the completion of hiring packages
- Assist employees in reporting on-the-job injuries to the agency with choice
- Decide which special skills and training employees need
- Work with the agency with choice to assure that employees are trained per Innovations and ISP requirements
- Refer prospective employees to the agency with choice and recommend dismissal of employees to the agency
- Communicate clearly and openly with the care manager, care worker, agency with choice, community navigator, and employees
- Work with the agency with choice to determine employee job duties and work schedule
- Along with the agency with choice, complete and update as necessary employee support agreements and an agency with choice agreement for each person hired
- Along with the agency with choice, give direction and feedback to employees and sign time sheets as requested by the agency with choice
- Comply with all applicable employment laws as requested by the agency with choice
- Review monthly reports from the agency with choice
- Utilize services as written in the ISP

Representative

A representative is a person who helps the employer of record or managing employer manage their supports. If the EOR or managing employer desires assistance, a representative is chosen. If the managing employer requires assistance, a representative is appointed. In either scenario, the representative must meet certain guidelines to ensure that the representative functions in the best interests of the beneficiary. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person who willingly accepts responsibility for performing tasks that the managing employer is unable to perform or needs assistance with completing. The representative must meet the following requirements:

- Demonstrate knowledge and understanding of the individual's needs and preferences and respect those preferences
- Demonstrate evidence of a personal commitment to the individual and be willing to follow the individual’s wishes while using sound judgment to act on the individual’s behalf

- Agree to a predetermined level of contact with the individual
- Is at least 18 years of age
- Is willing and able to comply with program requirements, including attending required training, and reading manuals/handbooks that describe program regulations
- Is approved by the employer to act in this capacity

The representative shall not:

- Be paid for being the representative
- Provide paid supports or services to the individual, including employees of agencies providing services, with the exception of guardianship services
- Provide paid trainings to their individual or their staff
- Have a history of physical, mental or financial abuse.

Specific duties of the representative are:

- Working with employer, care manager and care worker, financial support agency and/or community navigator to assure that the employer responsibilities are completed
- Making all or some of the decisions for the employer, depending on the individual and employer's desires and abilities to make those decisions
- Managing, with the employer, the IFDS budget for services as stated in the ISP
- Managing, with the employer of record, the employer functions
- Maintaining records as required

Starting with Individual and Family Directed Services

The care manager supports individuals and families interested in IFDS to start the process. Each individual enrolled in the NC Innovations Waiver is offered an opportunity to receive an orientation to IFDS at the time of the initial or annual plan. The care manager assists individuals and families who are interested in learning more about IFDS. When an individual or their legally responsible person expresses interest in directing services, the care manager will ask them to identify who will be the employer in self-direction and discusses the option of having a representative. The care manager will also help identify the model of self-direction they are most interested in (AWC or EOR). The care manager then revises the ISP to include community navigator for self-direction training and adds a long-range outcome to the ISP to address training needs.

Community navigator training for self-directed services is authorized to provide training to the individual and their legally responsible person. The community navigator provides training on the IFDS options if the individual is considering directing services and supports (AWC and EOR models). Training for the EOR model is typically authorized for 3 months, while training for the AWC model is authorized for 2 months. Self-direction training must be provided by qualified professional (QP) level staff. A community navigator provides IFDS training to the individual, potential employer, and/or potential representative. The prospective employer may ask other people who support the individual to attend the training. The community navigator provides the prospective employer and prospective representative with the IFDS employer handbook. The training and educational materials provide sufficient information to ensure that the individual and/or legally responsible person make informed choices about the degree they wish to self-direct services. The IFDS handbook and orientation materials should be kept for future reference, as they will be useful if the prospective employer decides to participate in IFDS. The orientation consists of information presented by the community navigator to cover the responsibilities and functions of the employer in EOR or the managing employer in AWC. The community navigator assists beneficiaries in locating and coordinating community resources and with direct assistance in individual and family directed activities.

The care worker will monitor the provision of IFDS training. If the community navigator providing training feels that additional units for training are needed to prepare the prospective employer or representative, the care manager will update the ISP to request additional training. Upon completion of the training, the community navigator will provide a certificate of completion. For EOR, the care worker will work with the community navigator and the employer or representative to complete the EOR assessment and Alliance EOR agreement to enroll the EOR with Alliance's provider network.

The care manager will complete a referral to the selected FSA (for EOR only) and complete an ISP update to add financial support services and EOR supplies. The care manager will also complete an ISP update to assign the services that will be self-directed to the FSA in the case of EOR or the agency with choice in the AWC model when the EOR is ready begin managing the services and employees.

Most prospective employers find it takes a minimum of 90 days from ISP submission to the date employees can begin providing services under IFDS. If the implementation date needs to change, the employer notifies the care manager who works with I/DD Utilization Management to change it.

Individuals continue to receive services from a provider agency until employees of the employer of record or employees of the agency with choice/managing employer begin to provide services under IFDS.

Managing the Individual and Family Directed Services in the ISP and Budget

Each person who participates in the NC Innovations Waiver has an ISP and individual budget. Individuals who choose to direct all or a part of their services will have an IFDS (self-directed) budget that is a part of the total individual budget. The amount of the individual budget will not change just because a person decides to participate in IFDS. The care manager informs the employer of the total cost of self-directed services that is reflected in the IFDS portion of the individual budget. The community navigator is available to train and assist the employer in managing the IFDS budget.

Individual Support Plan

The ISP is developed through a person-centered planning process and is led by the individual and/or legally responsible person for the individual to identify the individual's desires, strengths, needs and identification of services and supports.

The care manager will meet with the Individual, their legally responsible person and representative as applicable and review the ISP. A decision is made about the services that will be directed by the individual or family and the services to be provided under the provider direction option.

The ISP must be followed in service type, frequency and duration, and staff ratio as described in the ISP. A group service is defined as more than one individual receiving a service from the same staff at the same time. Individual services are provided at a one-to-one ratio.

The EOR and team can request changes to the ISP and request additional services as needs change. The individual or EOR must contact the care manager immediately to discuss and request any changes. The ISP will be updated by the care manager and submitted for review to Alliance Utilization Management department. Services must be authorized before the changes go into effect.

Using the IFDS Budget

NC Innovations funds are Medicaid dollars that the employer and Alliance must use wisely. Laws and regulations must be followed, and funds must be used to obtain services in the ISP. The employer must be a careful purchaser of services and remember to use existing personal and community resources before using NC Innovations and other public funds. Medicaid payment rates include two parts: the administrative portion; and a direct service portion. The administrative portion of the rate is used to pay for billing, required staff training, forms, and costs to meet other regulations. A portion of the rate pays for these expenses. The direct services portion of the rate is used to pay costs for staffing and benefits. The pay rate for staff cannot exceed the portion of the rate for direct services but may be less.

The employer of record has control over how the IFDS budget is spent within NC Innovations and Medicaid guidelines. In the agency with choice model, the agency with choice follows NC Innovations and Medicaid guidelines in spending NC Innovations funds on behalf of the Individual.

IFDS Budget

The IFDS budget is composed of the individual's authorized services and supports. The following principles must be followed in using the IFDS Budget:

- Expenditures tracked are not to exceed the annual authorized budget. The tracking is done by the financial support agency on behalf of the employer of record.
- All items purchased with NC Innovations Waiver funding must relate to the individual's needs and must be preauthorized in the ISP by the Alliance Health Utilization Management Department (UM).
- The financial support agency must provide the employer of record and/or representative with an expenditure report monthly.

Rates on the Alliance website for some services include an EVV allowance for the provider expenses related to maintaining and administering the Electronic Visit Verification (EVV) system. EOR rates may reimburse at a lower rate because EVV expenses are not paid by EORs.

For both provider-directed services and individual and family directed services, the total amount of the individual budget cannot exceed $135,000 per year. However, an individual may exceed the $135,000 waiver limit to ensure health, safety, and wellbeing only if the individual is utilizing supported living Level III and

- Lives independently without their family in a home that they own, rent or leases, and
- Requires 24-hour support.

Individual and Family Directed Supplemental Services

The following individual and family directed services provide support to individuals, guardians, and/or representatives who are self-directing services. These services are part of the self-direction budget as they are provider directed.

Employer Supplies

Employer supplies help an individual who is self-directing acquire supplies necessary to self direct services. These items must be pre-approved and specific to employment related supplies and training of employees. Only equipment and typical office supplies that are needed to perform the employer's duties may be purchased. Employer supplies may include the following (this is not an all-inclusive list.):

- Laptop, computer and printer used by the employer of record to carry out administrative duties of employer of record
- Electronic health records (EHR) software or subscription (annual or monthly) used to perform employer of record duties
- Windows or other operating system
- Monthly connectivity (internet) charges may be covered when it is required for the employer of record to perform employer of record duties such as processing timesheets, using financial support services portal or utilizing EHR software
- Microsoft subscription or the annual or monthly fees of other Office-comparable products annual or monthly fees.
- Annual subscription of virus/malware protection
- 1 year computer warranty

- Laptop bag (if computer is a laptop)
- Printer
- Ink or a subscription
- Office supplies (file folders, notebook, binders, pens, pencils, calculator, etc.)
- Computer repair - repair of equipment is covered for items purchased through the waiver for the employer of record if the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The EOR must own any equipment that is repaired
- One laptop computer and one EHR software may be purchased over the life of the waiver. EHR software may be upgraded more than once over the life of waiver, if necessary, to maintain functionality of software. Documentation to show that if upgrade is not completed, software does not function, is required from vendor to support request
- Employer supplies may also be utilized to pay for training and other work-related requirements, such as Hepatitis B vaccines for employees (this is not an all-inclusive list):
    - Training for new employees – CPR, first aid, bloodborne pathogens, medication administration, other individual-specific training
    - Hepatitis B vaccine for employees per bloodborne pathogen requirements
    - Protective equipment for employees such as gloves, CPR mask and first aid kit
    - Lock box and file cabinet to secure PHI and employee personal information

The following items are examples of items that will not be covered as employer supplies (this is not an all-inclusive list.):

- Wireless keyboards
- Mouse (unless the EOR is purchasing a desktop and the desktop does not include a mouse)
- Computer protective cases (outside of one laptop bag for EORs who utilize a laptop)
- Additional computer screens (a desktop computer should include one monitor)
- IT help desk service for support to operate the equipment

Start-up cost covered by employer supplies (blood-borne pathogen supplies, first aid kits, initial employment ads, background checks of employer of record/representative/initial employees requested by the FSA, and initial CPR and first aid employee trainings) can be paid through EOR supplies. The authorized start-up supply is billed to Alliance by the FSA.

All employer supplies must be requested through the FSA. Any spending covered by the FSS rate must not be included as costs under employer supplies and vice versa. When the EOR receives an item, the individual must mail, fax or email the packing slip or invoice to the FSA. It is important to do this so that the vendor can be paid. In cases where an account must be established and credit card payment is required, the FSA may choose to purchase and use a pre-paid credit card to ensure timely payment for employer supplies.

Alliance requires that a receipt be uploaded in the Alliance Claims System (ACS) at the time of claim submission. These claims are manually processed by an analyst who will check for a receipt to be on file at time of processing. The receipt needs to be saved using a naming convention that includes the individual's name and the date of service the receipt corresponds to. To be reimbursed, the FSA must submit an invoice and proof of purchase within 90 calendar days of the date of purchase to Alliance Health Finance department at finance@AllianceHealthPlan.org.

Individual Goods and Services

Individual goods and services funds are available to individuals who do not have the funds to purchase services, equipment or supplies that address an identified need in the ISP. The items or services must decrease the individual's need for other Medicaid services, or promote the individual's inclusion in the community, or increase the individual's safety in the home environment. These items must be pre-approved and may not exceed $2,000 annually. The FSA will pay for goods or services and bill Alliance. The ISP must outline how each of the applicable requirements are met, including that fact that the individual does not have the funds to purchase the item or service.

Accrued Funds

The FSA will inform EORs of the maximum pay rate available to staff based upon the service rate. EORs must set the pay rates for their staff. Employers of record accrue funds when the pay rate decided upon for staff is less than the portion of the rate allowed for direct service payment. These accrued funds may be used for staff expenses or costs outside of the base pay rate. Some examples are:

- Overtime
- Performance bonuses
- Mileage
- Raises
- Retention bonuses
- Training time or training expenses
- Health Insurance
- Paid leave or vacation
- Employee benefits

~~Payments may not be made directly to the individual, the EOR, the representative, or family. Instead, only the person (individual or entity) providing the service, supply or other item receives the payment.~~

Note: The preceding statement is removed. Financial Support Service agencies should follow Clinical Coverage Policy 8-P which includes ordering employment related supplies and paying invoices for other expenses.

Funds that have not been used by the first of the month that occurs four months after the end of the individual's plan year will be recovered by Alliance from FSA.

Note: Effective October 1, 2023, Alliance has waived this requirement due to the transitions from GTI while the reconciliation process is still underway.

Bonus payments to employees are limited to $5,000 per employee every 12 months.

Note: Effective October 1, 2023, Alliance has waived this limit due to the transitions from GTI while the reconciliation process is still underway.

Examples of Prohibited Expenditures

The following are examples of items that cannot be paid using NC Innovations funds. This list does not include all excluded items:

- Gifts for or loans to employees, family, or friends
- Rent, mortgage or periodic utility payments
- Payments for someone to be the EOR or the representative
- More than one laptop/computer or EHR software over the life of the waiver
- Experimental goods or services
- Items that are restricted under state law (N.C.G.S. §122C-60)
- Social or recreational items
- Vacation/holiday expenses
- Services covered by a third party
- Vehicle purchase or lease
- Animal purchase
- Items that are considered illegal

Requirements for Determining Allowable Expenditures

Some rules must be followed when using NC Innovations funding for EOR supplies, individual goods and services, or accrued funds. The fundamental rules are that everything purchased must be associated with the individual's needs and that the funds are used for services and supplies allowed by the NC Innovations Waiver. The following requirements are used to determine if expenditures are allowed under the EOR model:

- The expense must be related to the individual's disability needs and benefit the individual.
- The expense must be needed to maintain the health, safety, and well-being of the individual.
- The expense cannot be covered by another funding source.
- The expense must be clinically appropriate and adequately justified, and it must be directly related to a service in the current ISP.
- The expense must be covered by the applicable service definition and specifications.
- The expense must be the actual cost of the item after all applicable credits, such as refunds, rebates, and discounts, have been calculated.
- The expense cannot be associated with room and board charges.
- The expense cannot be prohibited under other federal, state, or local laws and/or regulations.
- The expense cannot be prohibited under NC Medicaid policies and procedures.

General Criteria for Services Covered

Medicaid may only cover procedures, products, and services when they are medically necessary are consistent with the individual's identified diagnosis and needs. There must not be an equally effective, more conservative, or less costly treatment that is available statewide. The procedures, products, and services are not primarily intended for the convenience of the individual, the individual's caretaker or the provider.

Individual Rights, Privileges and Responsibilities

Individuals and families utilizing the IFDS option have rights, privileges and responsibilities related to accessing information, managing employees, obtaining support, filing grievances and complaints, and withdrawing from the option. It is the policy and practice of Alliance to assure your basic human rights.

You have the right to:

- Be treated fairly and with respect regardless of race, ethnicity, religion, mental or physical disability, sex, age, sexual preference, or ability to pay
- Participate in making your ISP
- Limit access to your protected health information
- Get your services in a safe place
- Make an advance directive
- Agree to or refuse treatment services
- Get information in your own language or have it translated
- File a complaint, appeal or grievance without penalty
- Choose a provider within the Alliance network
- Use your rights with no negative action by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or Alliance
- Maintain the same civil and legal rights as anyone else

Individuals and/or legally responsible persons participating in the IFDS option must follow all applicable employment laws, rules and regulations regarding employment, Medicaid, the NC Innovations Waiver, and the IFDS option. Examples of laws, rules and regulations that may be applicable include, but are not limited to:

- Title VII of the Civil Rights Act of 1964,42 U.S.C. §§ 2000e, et seq.
- Age Discrimination in Employment Act, 29 U.S.C. §§ 621, et seq.
- The Americans with Disabilities Act, 42 U.S.C. §§ 12101, et seq.
- The Family Medical Leave Act, 29 U.S.C §§ 2601, et seq.
- The Fair Labor Standards Act, 29 U.S.C. §§ 201, et seq.
- Persons with Disabilities Protection Act, N.C.G.S. Chapter 168A
- Non-discrimination and Wage and Hour Act provisions in N.C.G.S. Chapter 95

The laws, rules, and regulations cited above are provided for reference only and are in no way offered as legal advice.

Grievances

Many concerns or complaints regarding a provider's services can often be resolved by direct communication with the provider. If you choose to allow the provider an opportunity to resolve the issue but are not happy with the outcome, you are encouraged to file a grievance by calling Alliance Member and Recipient Services (Mon-Sat 7 a.m.–6 p.m.) at 800-510-9132. If you prefer to discuss your concern informally before filing a complaint, contact the Alliance Office of Community and Member Engagement by calling Member and Recipient Services (Mon-Sat 7 a.m.–6 p.m.) at 800-510-9132.

When a grievance is submitted, someone will contact you within 5 working days to confirm receipt. A decision regarding the results will be provided to you within 30 business days of the initial call.

Records and Documentation

Service Documentation

The services must be provided specifically as described in the Innovations Waiver, Clinical Coverage Policy 8-P, the ISP and the provider plan/short-range goal (SRG) plan. The EOR/AWC provider, managing employer and representative (if applicable) is responsible for developing the provider plan/SRG's, making sure that the ISP and provider plan/SRG's are implemented as written, supervising employees, and ensuring services are timely and appropriately documented.

All services should be rendered in accordance with the type and duration described within the ISP and approved by Alliance's Utilization Management department. Should services need to change, the EOR, AWC, representative or individual should contact their care manager to request an ISP update.

Services must be documented before submitting time and billing claims to the FSA. The minimum service documentation requirements for NC Innovations services are listed in this handbook, Clinical Coverage Policy 8-P and the Record Management and Document Manual. **One of the essential responsibilities of the EOR/AWC provider, the managing employer and the representative is to make sure that employees document the provision of services as required.**

A community navigator, the EOR/AWC provider or the managing employer can provide information about documentation requirements during meetings and trainings with the managing employer (and representative, if applicable).

All Medicaid services must be billed within 90 days from the date of service. The FSS provider will establish a procedure including timelines for employee time to be reported in order for claims to be filed by the established deadline.

General Record Keeping and Review

Upon request, the EOR/AWC provider or managing employer (and representative, if applicable) must make service-related documentation available to Alliance and any other federal or state regulatory body responsible for oversight of Medicaid funding. This documentation can be used for:

- Monitoring the provision of services
- Monitoring the health and welfare of the individual
- Supporting a claim for reimbursement of NC Innovations services delivered to the individual
- Plan of correction development

All records must be accessible for inspection and must be brought to a chosen location for review when requested by Alliance or any other federal or state regulatory body responsible for oversight of Medicaid funding. The managing employer must also make documentation available to the EOR/AWC provider as requested or agreed upon. Failure to provide documentation can result in a plan of correction, overpayment finding or termination from the IFDS EOR/AWC model.

Record Maintenance

Service-specific or clinical documentation must be maintained for at least 10 years unless permission is granted by the NC Department of Health and Human Services for earlier destruction. The service records must be stored by the EOR/AWC provider. Any documentation about the individual or employees created or maintained by the managing employer or representative must be kept confidential and in a secure location. The community navigator and/or EOR/AWC provider can train the managing employer on how to maintain any records. Additionally, once the EOR agreement ends, clinical documentation is to be submitted to Alliance. For more information, see NC Medicaid Clinical Coverage Policy 8-P and the North Carolina Records Management and Documentation Manual.

Provider Network Evaluator from Alliance will:

- Monitor employers of record annually and provide any needed technical assistance to comply with individual family directed policies and processes
- Monitor community navigator agencies, financial supports agencies, and AWC providers at least once every two years.

Quality Management from Alliance will:

- Review incident reports
- Review a sample of back-up staffing plans at least annually to ensure that they function properly
- Provide technical assistance and training in completion of incident reports and service documentation

North Carolina Department of Health and Human Services role includes:

- Completing retrospective reviews of samples of ISPs and Individual and family budgets
- Reviewing financial supports providers
- Reviewing a sample of community navigator monitoring reports

Medicaid Fraud and Abuse

The North Carolina Department of Health and Human Services and Alliance want all individuals and provider staff to be informed that anyone with knowledge of Medicaid fraud or abuse should report it by calling toll-free **1-877-DMA-Tipl (1-877-362-8471), 919-814-0181, or online** at https://medicaid.ncdhhs.gov/meetings-notices/ocpifraud-waste-and-abuse.

You may also contact the Alliance hotline at **855-727-6721**. Visit the link below to learn more about how to report potential Medicaid fraud or abuse. AllianceHealthPlan.org/contact/reporting-medicaid-fraud-and-abuse/.

Medicaid fraud or abuse includes any of several dishonest acts, such as when you allow someone else to use your Medicaid card or when a provider bills for unnecessary medical procedures.

Other examples of Medicaid fraud include but are not limited to:

- Billing for any services not actually performed, known as phantom billing
- Billing for a more expensive service than was actually rendered, known as upcoding
- Billing for several services that must be combined into one billing, known as unbundling
- Billing twice for the same medical service
- Giving or accepting something in return for services, known as a kickback
- Bribery
- Billing for unnecessary services
- False cost reports
- Embezzlement of individual funds
- Falsifying timesheets or signatures in connection with the provision of services

For additional information you can also contact the Office of Compliance and Program Integrity at the NC Department of Health Benefits (DHB) at 919-814-0000.

Back-up Staffing, Risk and Emergency Planning

Back-up Staffing

As an employer of record and/or representative, planning for employee vacancies and absences is important as you direct your services. There will be times when your regularly scheduled employee cannot work. You must arrange for "back-up" employees to fill in when your regular employee is not available and for emergency situations. It is important to ensure adequate support is available to meet the individual's needs. The ISP must describe how the individual will get their needs met if an employee is absent or if any unforeseen circumstance prevents the individual from functioning as usual.

Risk and Emergency Planning

Risk and emergency planning is important and must be made to address potential emergency situations that can create safety issues or barriers to care delivery. Having a plan for dealing with different types of emergencies, such as medical emergencies, hospitalizations, power/electrical outages, severe weather, fires, evacuation planning (including evacuation routes and shelter locations, supplies, etc.), and other natural disasters can help keep you safe and reduce the risk of injury. Potential emergency needs for the individual are identified as part of the risk/support needs assessment process that is used in developing the ISP. You will need to include in your plan a way to test your plan and document the tests. Employees must be trained on the plan and what to do in an emergency.

The crisis plan section of the ISP must state how each identified risk will be managed and must identify training needs of anyone responsible for implementation of managing a risk management strategy or strategies. A back-up plan needs to be developed to address absence of staff and who to call when back up staffing is needed. The plan must be tested/reviewed at least quarterly.

Monitoring of Back-Up Plans

Alliance care workers along with Quality Management (QM) staff will monitor back-up and emergency plans as a part of monitoring of services. Any situation that is identified as a health and safety issue for the individual is immediately addressed with the employer of record or representative.

Ending Self-Directed Services

Individuals in IFDS may elect to return to provider-directed services at any time by informing the care manager. In the case that an EOR becomes incapacitated and an alternate EOR or representative cannot be immediately identified, the individual may end IFDS services. To end services under the IFDS model, the care manager will complete an ISP update to transfer to a selected provider and terminate IFDS-specific services. The care manager will inform the AWC or FSA and community navigator of the date of termination of IFDS. The AWC or EOR must inform staff that they are no longer employed under the IFDS model. In the EOR model, the FSA must return any unused funds to Alliance.

An Individual self-directing services may be removed from IFDS involuntarily under any one of the following circumstances:

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

Alliance may remove an individual from individual and family supports, after consultation with NC Medicaid, in instances when the individual's health and safety are compromised, or after an employer or managing employer has made the same major mistake three different times in one year. A major mistake includes the inability to implement the ISP and/or the inability to comply with NC Innovations requirements. Alliance will make reasonable efforts to provide the individual with technical assistance and/or support prior to terminating IFDS services. The rationale is that each individual should be given every opportunity to be successful in self-directed service options should they desire to participate.

Termination of the IFDS option will occur immediately in the following circumstances:

- The individual's health and/or safety are compromised
- Misuse of Innovations Waiver funds
- Suspected fraud or abuse of funds
- No approved representative when one is required
- Refusal to accept required community navigator services
- Refusal to allow care worker monitoring
- Refusal to participate in Alliance, state or federal monitoring

If it is determined at any point during monitoring or follow-up by Alliance staff that the person immediately needs to be returned to the provider directed option to ensure their health and safety, this can be recommended. The following steps are followed:

- Concerns and/or allegations of major problems with the implementation of IFDS are reported to Alliance
- Alliance staff investigates the concerns or allegations of major problems and reviews all available plans of correction and documentation
- Depending on results of the investigation, Alliance may recommend termination of individual and family directed services. If the removal is an emergency, Alliance staff contacts the Chief Medical Officer or designee and obtains a decision regarding removal. This decision is reported to DHB the first working day following the removal
- Termination from the IFDS option is normally at the end of a month; however, when the termination is due to a threat to the beneficiary's health and safety, such as physical abuse, termination occurs immediately, and provider-directed services resume immediately
- If the EOR or managing employer disagrees with the decision of Alliance and DHB, they may file a reconsideration request or a grievance
- The care manager will complete an ISP update to transfer to a selected provider and terminate IFDS-specific services. The care manager will inform the AWC or FSA and community navigator of the date of termination of IFDS. The AWC or EOR must inform staff that they are no longer employed under the IFDS model. In the EOR model, the FSA must return any unused funds to Alliance.

Important Links

- AllianceHealthPlan.org/document-library/59271
- https://medicaid.ncdhhs.gov/media/11377/open
- AllianceHealthPlan.org/document-library/59679/
- https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/policies-and-procedures/records-management-and-documentation-manual