

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information (1 of 3)

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

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

Supports Waiver (3.5)

C. **Type of Request: new**

New to replace waiver

Replacing Waiver Number:

0429.04

Migration Waiver - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number

(if applicable):

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

Waiver Number: NC.0663.R00.00

Draft ID: NC.10.00.00

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

Regular Waiver

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

11/01/08

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

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

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

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

2. Brief Waiver Description

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

The State of North Carolina requests a 1915(c) Home and Community Based Waiver for Individuals with Developmental Disabilities to provide services and supports to participants with developmental disabilities, mental retardation, and autism, in their homes and communities. This Supports Waiver will be operated by the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse in close cooperation with the North Carolina State Medicaid Agency within the Department of Health and Human Services. This HCBS waiver supports persons with developmental disabilities, mental retardation, and autism, who meet ICF-MR level of care criteria to remain living at home and in the community as an alternative to institutionalization.

Services offered under the Supports Waiver include: personal care, home and community supports, respite, crisis services, behavior consultation, adult day health, day supports, transitional work services, long term vocational supports, supported employment, individual caregiver training and education, personal emergency response system, specialized consultative services, specialized equipment and supplies, transportation, vehicle adaptations, home modifications, and augmentative communication. Case Management will be provided through the state general plan. Assessments of each participant will include a uniform Risk Assessment Tool and Prioritization Tool. The Supports Waiver also includes the option of self-directed services with the assistance of a support broker and financial management service.

The goals of the Supports Waiver are to:

- Ensure the well being and safety of the people served;
- Maximize participants' self-determination, self-advocacy and self-sufficiency;
- Increase opportunities for community integration through work, life-long learning, recreation, and socialization;
- Deliver person-centered services that leverage natural and community supports; and
- Provide quality services and improve outcomes.

Objectives in the Supports Waiver include:

- 1) Enhancing the focus on person-centered planning and the alignment of services and supports with person-centered plans;
- 2) Reforming day supports, supported employment, and long term vocational supports to ensure that participants are progressing towards their employment goals, have meaningful daily activities;
- 3) Reforming residential service to facilitate smaller community congregate living situations;
- 4) Facilitate living and working in the Most Integrated Setting; and
- 5) Improving outcome-based quality assurance systems.

Participants in the Supports Waiver have a Case Manager who assists them in finding and connecting with community resources, developing a Person Centered Plan, ensuring the participant's health and safety needs are met, facilitating services and supports are provided in the Most Integrated Setting, and ensuring the participant is satisfied with the services and supports they are receiving. Services are delivered through a network of licensed and endorsed community-based service providers throughout the state that are charged with implementing waiver participants' Person Centered Plans by providing services and supports that enhance the participant's quality of life as defined by the participant. Minors will be considered as a family of 1 for financial eligibility. National Accreditation will be required of providers of Comprehensive Waiver services within 1 year of implementation.

This Supports Waiver contains a cost limit of \$17, 500. It will be implemented in conjunction with a higher cost HCBS Comprehensive Waiver under separate application which contains a cost limit of \$135,000.

3. Components of the Waiver Request

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

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

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

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

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
 - No
 - Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
 - Yes

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

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
 This Supports Waiver will be available throughout the state except to those who live in the Counties of Carrabus, Rowan, Stanly, Union and Davidson which is served by the separate Piedmont Innovations Waiver.
- Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
 - C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
 - D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
 - E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
 - F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
 - G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
 - H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
 - I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
 - J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports

that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
Four (4) Stakeholder workgroups were conducted in early 2008 which reviewed and provided input into the Application; participants include individuals with disabilities, family members, providers, case managers, and staff from state sub-entities. Three (3) public forums were conducted during April and May 2008 when members of the public at large as well as stakeholders were presented with information regarding the contents of this waiver. This information was also posted on the DMH/DD/SA website with public access. DMA officially posted all waiver service definitions on the DMA website for public comment.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Catharine
First Name: Goldsmith
Title: Chief Behavioral Health Section
Agency: Division of Medical Assistance
Address: 1985 Umstead Drive
Address 2: 2501 Mail Service Center
City: Raleigh
State: North Carolina
Zip: 27699-25
Phone: (919) 855-4295 **Ext:** TTY
Fax: (919) 715-9451
E-mail: catharine.goldsmith@ncmail.net

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

Last Name: Wainwright
First Name: Leza
Title: Co-Director
Agency: Division of Mental Health-Developmental Disabilities and Substance Abuse Services
Address: 3001 Mail Service Center
Address 2:
City: Raleigh
State: North Carolina
Zip: 27699-3001
Phone: (919) 733-7011 **Ext:** TTY
Fax: (919) 508-0951
E-mail: Leza.Wainwright@ncmail.net

8. Authorizing Signature

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

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

Signature: Kris Horton
State Medicaid Director or Designee
Submission Date: Sep 22, 2008

Last Name:	Lawrence
First Name:	William
Title:	MD Director
Agency:	Division of Medical Assistance
Address:	1985 Umstead Drive
Address 2:	2501 Mail Service Center
City:	Raleigh
State:	North Carolina
Zip:	27699-2501
Phone:	(919) 855-4100
Fax:	(919) 733-6608
E-mail:	William.lawrence@ncmail.net

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

North Carolina currently operates one Comprehensive Waiver addressing the support and service needs of participants with developmental disabilities, including participants with mental retardation and autism spectrum disorders. The current Comprehensive Waiver has been in effect since September 1, 2005 and will expire October 31, 2008. The Comprehensive Waiver was intended to move the system of services and supports for participants with Developmental Disabilities forward with system transformation. The Comprehensive Waiver emphasized a focus on participant centered outcomes, Person Centered Planning and flexibility within the available service array. The state system has continued to benefit from our learning during the operation of the Comprehensive Waiver.

The development of a two tiered waivers system of services and supports for persons with Intellectual and Developmental Disabilities is an opportunity to create a system that is more responsive to the individual needs of persons while addressing the need to be fiscally responsible. Persons with higher support needs will be in the Comprehensive Waiver with a cost limit of \$135,000. Those with lower support needs will be in the Supports Waiver with a cost limit of \$17,500. The service array for each of the two waivers will be designed specifically within each waiver, focusing on the expected support needs of participants targeted within the waiver(s).

The only service that is provided in the #0429 Comprehensive waiver and has not been carried over to the #0663 Supports waiver is Residential Supports. The annual cost of Residential Supports exceeds the upper cost limit of the Supports waiver. Individuals who need supports in their home may access Home and Community Supports and/or Personal Care services. Individuals who require Residential Supports will be transitioned into the Comprehensive waiver (#0662). After reviewing gaps in the service array of the #0429 Comprehensive waiver, new definitions were added and existing definitions were clarified.

We recognized that the service supports in the vocational/employment area needed to be strengthened. The Day Support definition was revised so that vocational services can not be provided in a licensed segregated setting. The Supported Employment definition was altered to better clarify group services and individual supports. The option for an individual to have a personal business or microenterprise was added to the Supported Employment definition. Long Term Vocational Supports, a new service definition, was added to support the individual who no longer needed the services to learn the job but needed some level of supports in their work because of medical or behavioral reasons.

The #0663 Supports waiver includes new definitions for behavioral/crisis supports. The Behavioral Consultation Service will provide support and monitoring to prevent or decrease crisis situations. Crisis Respite will be a short term respite service for individuals who are in crisis or have extreme behavioral challenges.

The #0663 Supports waiver also has changed the staff qualifications for staff that provide Respite Services. In the #0429 Comprehensive waiver there was no minimum education requirement. In the #0663 Supports waiver the minimum education requirement will be a High School Diploma or a GED. This requirement will be effective 18 months after the implementation of the waiver to allow staff time to obtain the necessary education.

The #0663 Supports waiver will provide individuals who are living in their own home or in their family's home the opportunity to self-

direct waiver services.

During the transition from the current waiver, #0429, to the new waivers, #0663 Supports waiver, and the Comprehensive waiver #0662 the individual budget/cost summary included in the Plan of Care, will be used to determine the current cost of service needs and entry into each waiver per participant. The individual budget/cost summary used to determine entry into a specific waiver will not include one-time costs such as home modifications, adaptive equipment, vehicle modification, specialized equipment or other one-time costs. Persons with higher support needs will be in the Comprehensive waiver #0662 with a cost limit of \$135,000. Those with lower support needs will be in the Supports waiver #0663 with a cost limit of \$17,500. No individual, regardless of the current cost of their support needs will receive a reduction in services and supports at the time of transition to the new waivers.

Each of the waivers has a specific service array and entry criteria designed to more effectively address the needs of participants. Participants currently served under the CAP-MR/DD Comprehensive waiver will initially be placed into the specific waiver that corresponds to their current services as outlined in their person centered plan and corresponding individual budget reflected in a cost summary of services. The individual budget/cost summary used to determine entry into a specific waiver will not include one-time costs such as home modifications, adaptive equipment, vehicle modification, specialized equipment or other one-time costs.

Participants currently served under the #0429 Comprehensive waiver will initially be placed into either the #0662 Comprehensive waiver or the #0663 Supports waiver. The recipient will be placed into the specific waiver that corresponds to their current services as outlined in their Plan of Care and corresponding individual budget reflected in a cost summary of services. The individual budget/cost summary used to determine entry into a specific waiver will not include one-time costs such as home modifications, adaptive equipment, vehicle modification, specialized equipment or other one-time costs. Persons with higher support needs will be in the Comprehensive waiver #0662 with a cost limit of \$135,000. Those with lower support needs will be in the Supports waiver #0663 with a cost limit of \$17,500.

Prior to implementation of the waivers, training will be provided regarding the transition process, to waiver participants and family members, case managers, providers of waiver services, and staff of Local Management Entities (LME). Information regarding the transition will be made available to waiver participants and the overall system through letters of notification to all waiver participants, web postings, stakeholder meetings, and face to face meetings with case managers. Participants in the Supports Waiver will be given the option to choose self-directed service to begin November 1, 2009. No individual, regardless of the current cost of their support needs will receive a reduction in services and supports at the time of transition to the new waivers. Information regarding the transition will be made available to waiver participants and the overall system through letters of notification to all waiver participants, web postings, stakeholder meetings, and face to face meetings with case managers. Case managers will meet individually with each waiver participant on their caseload to review the participants' current service needs identified in the Plan of Care. During this meeting the participants will be informed of their opportunity to request a Fair Hearing if there is a reduction in services, duration or frequency. However, no individual, regardless of the current cost of their support needs will receive a reduction in services and supports at the time of transition to the new waiver.

The waivers are projected to be implemented November 1, 2008. Between November 2008 and December of 2009 the Division of Mental Health, Developmental Disabilities and Substance Abuse services and the Division of Medical Assistance will collect and analyze data (paid claims, costs summaries, etc) regarding the actual costs of services/supports, based on one year of data, per participant. In January 2010 this information will be provided to participants, families, case managers and LME(s). If during the person centered planning process it is determined that the participant has support needs that exceed the individual cost limit for their waiver OR places them in another waiver with a lower cost limit, the participant will be transitioned to the waiver that most appropriately addresses their support needs or offered alternative services. In any situation of a reduction, denial, or termination of services appeal notice and fair hearing process are provided.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

● **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for the operation of this waiver. The North Carolina Division of Medical Assistance (DMA) oversees the overall operation of the waiver according to federal and state guidelines. The Divisions cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each Division's responsibilities. The Memorandum of Understanding is renewed every three years and can be amended as needed.

State Operating Agency – Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)

- o Manage and allocate waiver slots and report quarterly on slot allocation
- o Monitor the prioritization process including the use of the Prioritization Tool
- o Collect, aggregate and analyze statewide and sub-state incident and complaint data
- o Monitor estimated budgets and expenditures of the waiver program to ensure cost neutrality.
- o Develop expectations through the promulgation of performance contracts with Local Management Entities (LMEs)
- o Routinely monitor the performance of LMEs
- o Conduct yearly accountability audits of the LMEs and providers using a standardized review instrument
- o Conduct surveys of participant and family outcomes
- o Conduct reviews a sample of Person Centered Plans (PCP) and using a standardized survey instrument. The standardized survey instrument will include items regarding Level of Care.

- Division of Medical Assistance (DMA)
 - o Conduct monthly audits of a sample of PCPs for waiver participants.
 - o Conduct fiscal audits of the waiver programs.
 - o Review data/evidence from DMH/DD/SAS regarding the waiver program.
 - o Reviews all policies developed by DMH/DD/SAS regarding implementation and operation of the CAP-MR/DD Waiver.
 - o Require remediation by DMH/DD/SAS for any identified issues and conduct ad hoc reviews of the waiver program.
 - o Meet with DMH/DD/SAS on at least a quarterly basis to review trends and to communicate information on any new CMS policies and procedures.
 - o Enroll qualified providers.
 - o Assure family/recipient awareness and choice for all available waiver services
 - o Oversee the performance of the Utilization Review vendor (UR vendor).
 - o Oversee the performance of the Rate Setting vendor.
 - o Ensure that endorsed CAP-MR/DD Waiver providers sign the Medicaid Provider Agreement

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*:
The Division of Medical Assistance (DMA) contracts with a statewide vendor to conduct utilization review and service authorization for the Supports Waiver.

The Division of Medical Assistance contracts with a vendor to conduct rate setting.

The Division of Medical Assistance contracts with a vendor to operate a claims processing data systems to ensure all claims are paid in accord with established WAIVER COVERAGE POLICY and rates.
 - No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
- Not applicable**
 - Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:
 - Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

The Local Management Entities (LME) are responsible for the administration and operation of 1915 (c) waiver programs in their areas. The functions of the LME include:

The LME must assure that the policies and procedures for the waiver and all programs in the public MH/DD/SA service system are followed. They are responsible for the health, safety and welfare of participants receiving services, for assuring

integrity and improvement of the provision of services and supports with the Person Centered Plan.

Local Management Entity (LME) responsibilities are as follows:

- o Serve as the single portal for HCB services eligibility.
- o Provide information to waiver participants about their rights, protections * Assure family/recipient awareness and choice for all available waiver services and responsibilities, including the right to change providers
- o Resolve issues related to participants' health and safety or service delivery that are unresolved by the case manager
- o Conduct annual health and safety reviews for unlicensed Alternative Family Living (AFL) residences.
- o Manage appeals for levels of care
- o For lead agency billed services, process billing, verify that billing does not exceed cost summary, transmit billing, post remittance advises, research denials and rebilling as indicated, and order/purchase non-service items
- o Maintain service provider list, recruit providers to address unmet needs, provide training and technical assistance to provider agencies endorsed to provide services in the lead agency catchment area
- o Assure family/recipient awareness and choice for all available waiver services
- o Utilize Paid Claims as warranted by specific situations as needed with follow up on any discrepancies noted.
- o Provide or arrange for 24/7/365 crisis response system.
- o Conduct the endorsement process for providers.
- o Conduct ongoing monitoring of endorsed providers based on a standardized monitoring protocol and scheduled based on a confidence level calculation.
- o Provide technical assistance to providers.
- o Oversee and provide follow-up of to ensure implementation of plans of correction.
- o Implement a quality improvement system that includes an incident review committee, external consumer/family advisory committee (CFAC), quality improvement committee, and client rights committee.
- o Receive, track and respond to participant complaints and appeals.
- o Receive, track and respond to incident reports from providers; prepare incident trend reports for DMH/DD/SAS.
- o Assess community service needs and develop provider capacity.
- o Monitor and oversee case managers working with individuals leaving state facilities to ensure they are monitoring health and safety and implementation of the PCP.

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

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

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Appendix A: Waiver Administration and Operation

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

DMH/DD/SAS Monitors the LME through the use of a performance contract.

The Division of Medical Assistance contracts with a independent vendor to conduct utilization review and service authorization for CAP-MR/DD Services..

The Division of Medical Assistance contracts with an independent vendor to conduct rate setting. The independent vendor is monitored by contract outlining the rate setting process.

The Division of Medical Assistance contracts with a vendor to operate a claims processing data systems to ensure all claims are paid in accord with established WAIVER COVERAGE POLICY and rates. The independent vendor is monitored according to the contract outlining the responsibilities of the claims processing data systems.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: DMHDDSAS monitors the LMEs by:
- o Developing expectations through the promulgation of performance contracts with LMEs
 - o Routinely monitoring the performance of LMEs
 - o Conducting yearly accountability audits of the LMEs and providers using a standardized review instrument
- DMA monitors the utilization review vendor and the vendor contracted to complete rate setting by.
- o Developing expectations through the promulgation of performance contracts with LMEs
 - o Monitoring processes and timelines.
 - o Reviewing a sample of PCPs plans monthly to ensure the appropriate review and authorization of services.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the

following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Performance Measure: a.i.a.1. DMA will monitor DMH's management of waiver resources across the state to assure full utilization of waiver slots. N=Number of waiver slots that are filled
D=number of saiver slots statewide (less those held in reserve).

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Enrollment Process Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input style="width: 100%;" type="text"/>
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Performance Measure:

Performance Measure: a.i.a.2. DMA will monitor monthly waiver expenditures and require DMH to take action to address expenditures if expenditures deviate from anticipated level for that month. N=Actual Expenditures; D=Expected Expenditures

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Performance Measure: a.i.a.3. Level of Care decisions will be made in compliance with waiver requirements and clinical criteria. N=Number of Level of Care decisions reviewed by DMA that are made in compliance with waiver requirements; D=Number of Level of Care Decisions that are reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA PCP Reviews

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure a.i.a.4. The Utilization Review (UR) vendor will authorize services in only those Person Centered plans that include all required components. N=Number of UR reviewed Person Centered Plans that include required components; D=Number of UR reviewed Person

Centered Plans

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH PCP Review

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

a.i.a.5. Services are delivered within required time frames following determination of level of care and eligibility for waiver services. N=Number of persons sampled who received services within established timeframes. D=Number of waiver participants in sample.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Enrollment Data

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: DMH's LOC Reveiw Report	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: TCM agency/LME Money follows the person
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

a.i.a.6. Waiver services approved by the Utilization Review vendor that meet state and waiver service requirements. D=total number of UR approved recipient waiver services that meet waiver service requirements. D=Total number of UR reviewd recipient waiver services that are reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Review

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Money Follows the Person, LME and TCM agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.a.7. DMA will enroll only those waiver provider who have signed a provider enrollment agreement; who are endorsed by the local managing entity, licensed or credentialed in compliance with waiver requirements. N=Total number of sampled providers who are enrolled by DMA who meet waiver requirements. D=Total number of providers sampled who are enrolled as waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

list of Medicaid enrolled waiver providers

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure: a.i.a.8. DMA monitors DMH's oversight of the LME's provider monitoring and performance improvement activities per waiver provider contracts. N=number of waiver providers reviewed by LME's for whom there are documented performance improvement plan. D=Number waiver providers reviewed who required performance improvement plans

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH Monitoring Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LMEs
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure: a.i.a.9. DMA monitors DMH's implementation and oversight of the waiver's Critical Incident Reporting protocol to assure compliance or performance improvement.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Agregated Reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: as needed	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure: a.i.a.10. DMA requires DMA to take action when DMA has findings regarding quality assurance and quality improvement activities based on the evidence generated in reviewed aggregate reports.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Aggregated reports from DMH and DMA

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input style="width: 100%;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
- a.i.a.1: The Local Management Entities (LMEs) perform the participant waiver enrollment function for DMA. The LME performs intake activities, takes applications for entry into the waiver, prioritizes applicants and refers prioritized applicants to the Level of Care determination agency. The LME will maintain data on the number of people who apply for MR/DD services and the proportion of those people who are accepted. The data will be submitted annually to the DMH/DD/SAS QM Team who will analyze and report on the aggregated data. Additionally, one of DMA's responsibilities is to manage waiver enrollment against approved limits. DMA has assigned this function to DMH/DD/SAS. This function includes the management of all waiver slots by allocating and tracking assigned slots, re-assigning unused slots and tracking inactive slots. DMH/DD/SAS also maintains, allocates and tracks reserve capacity slots as well as emergency slots. DMH/DD/SAS provides DMA with quarterly and annual Slot Allocation Reports that indicate slots allocated, reserved and emergency slots available and assigned, slots re-assigned, inactive slots and total slots. The data also reflects where the assigned slots are located (LME) and any change of location when a participant moves as well as the purpose for each emergency slot request.
- a.i.a.2: In order to manage expenditures against approved levels, DMA, each month, compares the actual expenditures (provided by DMH/DD/SAS Budget Team) with the estimated waiver budgets, analyzes the data and generates an Expenditures Report. Action will be taken by DMH/DD/SAS to manage expenditures if they trend upward.
- a.i.a.3: When DMA reviews a Person Centered Plan (PCP) and finds the Level of Care determination to be questionable, they will require Murdoch Center or the responsible LME to review the LOC and determine if the participant needs to be re-evaluated by the Murdoch LOC evaluator. When other reviewers question a LOC determination, they notify DMH/DD/SAS who requires the responsible LME to review the LOC and determine if the participant needs re-evaluation by the Murdoch evaluator. If the LME finds the LOC determination in question to be correct, the LME notifies DMA or DMH/DD/SAS of their decision and no further steps are taken.
- a.i.a.4 and a.i.a.6: DMA evaluates if the UR vendor has authorized services in conformance to waiver requirements such as assessments conducted as required, required signatures are included and strategies in the plan address assessed needs. DMA conducts these reviews each month. One of the waiver requirements DMA monitors is the requirement that enhanced services direct care staff be trained to provide the enhanced service before the services are implemented for the participant. DMA reviews for documentation in the PCP that supports this requirement. DMA also reviews for evidence that a review was conducted regarding the necessity of specific waiver services before they are authorized. Findings will be documented by the reviewer. Quarterly and annual reports will be compiled by DMA and the annual aggregate data will be analyzed and reported by the DMH QM Team.
- a.i.a.5: Waiver service must be commenced within prescribed timeframes following enrollment in the waiver. Compliance with this standard will be monitored, tracked and reported to DMA. DMH will be expected to take corrective action with

LMEs to bring providers into compliance with this standard.

a.i.a.7: The enrollment process includes credentialing, endorsement by the LME, and licensure verification. DMA completes this verification to ensure that all providers are in good standing in the community. DMA will monitor Provider Services to assure compliance with these requirements and the execution of the Provider Agreement, which includes requirements for participant rights, compliance with federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and the provision of services to Medicaid eligible recipients of the same quality as are provided to private paying individuals without regard to race, color, age, sex, religion, disability, or national origin. The contracts are overseen by the DMA Contract Unit. The DMA Program Integrity Section performs post-payment reviews of provider claims and services to determine the appropriateness of claim submission practices and verifies providers' compliance with Medicaid Provider Participation Agreements/contracts.

a.i.a.8: DMA holds a Memorandum of Understanding with DMH covering responsibilities of DMH as the Operating Agency of this waiver. DMH is required to oversee the activities implementing the waiver including provider qualifications, level of care determinations, risks assessments and safety plans as well as staffing qualifications.

a.i.a.9: DMA will monitor DMH's implementation of the critical incident reporting protocol to assure that critical incidents are being reported and handled according to policy. Additionally DMA will review to determine that corrective actions have been implemented when necessary.

a.i.a.10: DMA reviews and evaluates the aggregated reports of all discovery and remediation activities, before and after the waiver is implemented, to evaluate the effectiveness of the discovery and remediation activities conducted for the waiver. This includes activities conducted by case managers and all other service providers, LMEs, the UR vendor and DMH/DD/SAS. These activities and reporting processes are developed by DMH/DD/SAS in conjunction with DMA; however, DMA retains ultimate approval authority.

b. Methods for Remediation/Fixing Individual Problems

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

DMA's responsibilities include review of reports generated by DMH/DD/SAS and LMEs and review of all policies and procedures and information governing the CAP-MR/DD waiver. DMA ensures that CAP-MR/DD waiver slot allocations do not exceed approved limits and CAP-MR/DD waiver costs do not exceed estimated costs. DMA reviews participant PCP/POCs to ensure all CAP-MR/DD waiver requirements are met and ensures that CAP-MR/DD waiver services have prior authorization. DMA sets the standards for and oversees the provider enrollment process and all Medicaid provider agreements. Additionally, DMA will communicate to DMH, the LMEs and providers any information regarding CMS policies, procedures, and technical assistance opportunities. This communication will take place through memos, letters, phone calls and the DMA Provider Medicaid Bulletin.

DMA collaborates with DMH in the development of all CAP-MR/DD waiver policies, rules, procedures, rates and service definitions prior to giving final approval to each. DMA also reviews reports submitted by DMH/DD/SAS. If DMA discovers an issue with any item reviewed, the reviewer will notify DMH/DD/SAS. DMH/DD/SAS is required to correct issues brought to their attention. If DMA finds an issue with any report they review, they will return it to DMH/DD/SAS and ask for corrections, amendments, more analysis, etc. In some cases DMA will meet with DMH/DD/SAS to discuss the finding. DMH/DD/SAS will correct the issues and reports to DMA's satisfaction and inform DMA when this has occurred. DMA may then opt to conduct a validation review.

a.i.a.1: DMA reviews the DMH/DD/SAS Slot Allocation Reports and if they need more information or have a question about the data, requires that DMH/DD/SAS respond to their questions and/or findings. DMH/DD/SAS provides the requested data and/or additional information or description of how the data was determined. DMA and DMH/DD/SAS may meet to discuss and evaluate the data together.

If it is discovered that a slot was allocated to an LME in error, the slot remains with the participant and the slot is replaced in the slot pool from the reserve capacity slots.

a.i.a.2: If there is a finding related to expenditures DMA will meet with DMH to find out if there were extenuating circumstances that caused the expenditures to exceed the budget. There may be a need for DMA to develop a fluid process to transfer funds from one area to another to cover cost overruns.

a.i.a.3: If, based on their review of the PCP, DMA has findings regarding an individual's LOC, DMA notifies the LME who in turn notifies the case manager. If the participant's LOC is to be re-evaluated, the case manager updates the LOC eligibility determination documents, including the addition of other evaluations, then submits the updated eligibility determination packet to the LME. The LME submits the eligibility determination packet to the Murdoch Center LOC evaluator for a new

eligibility determination. If this re-determination of LOC indicates that the previous LOC determination was incorrect, DMH/DD/SAS may provide technical assistance to the Murdoch reviewer.

a.i.a.4 and a.i.a.6:

If the DMA reviewer finds issues with the UR vendor’s authorization of services, DMA follows up with the vendor with technical assistance and training to ensure the errors are not repeated. The case manager is also notified and required to amend the CNR as needed. DMA also notifies DMH/DD/SAS of the findings so that other reviewers can be alerted to monitor for the issues.

DMA maintains data of the results of these PCP reviews, including issues encountered and timeliness of submission and resubmission. Quarterly reports will be written by DMA. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

a.i.a.7: DMA processing of enrollment applications is delayed when there is provider error, incomplete information, or delays in obtaining credentialing, endorsement or licensure information from another agency. If the provider cannot provide all required documentation, DMA will deny enrollment. If a provider’s endorsement is revoked by an LME, the LME notifies DMA and DMA immediately revokes the provider’s enrollment.

Any provider who refuses to sign the Enrollment Agreement will not be enrolled. If the Program Integrity Section finds the provider’s claims to be out of compliance or finds the quality of care does not meet required standards, they require immediate recoupment. NOTE: If there are quality of care findings or other issues such as discrimination the Program Integrity Section refers the findings to the Division of Health Services Regulation for possible licensing remediation.

a.i.a.8, a.i.a.9 and a.i.a.10: DMA will monitor DMA's implementation of the MOU and work with DMH in a collaborative manner to resolve issues of non-compliance in the field. DMA will provide technical assistance when indicated to assist DMH on the development of policies, procedures, service definitions, and training issues to assure ongoing collaboration between the two divisions.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Information on waiver providers, participants and services are currently available in multiple data systems throughout the DMH/DD/SAS. An electronic database will be developed by the DMH/DD/SAS to bring together waiver-specific data into one location that can be accessed by all members of the DMH/DD/SAS waiver staff who generate, collect and review waiver data. The database will be operational by December 31, 2009.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	<input type="text" value="0"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	<input type="text" value="0"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	<input type="text" value="0"/>	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

North Carolina residents who live in their own home or reside with their family with some support and service needs that can be met within the cost limit of \$17,500. Participants who choose not to self direct can live in licensed residential facilities.

Additionally, individuals who reside in the of counties Carrabus, Davidson, Rowan, Stanly, and Union which are served with the Piedmont Innovations Waiver will not be served by this Supports Waiver.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based

services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

Specify:

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

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

North Carolina residents who live in their own home or reside with their family with some support and service needs that can be met within the cost limit of \$17,500.

The MR 2 assessment form documents not only the level of care, but provides for a comprehensive medical evaluation and information to help determine intensity of support needs. Each participant who is admitted into the waiver will also be assessed to determine level of support needed through the application of the North Carolina-Support Needs Assessment Profile (NC-SNAP), which provides for a determination of intensity of support needs. In addition, a psychological evaluation, including adaptive functioning assessment is required during the assessment process. Finally, a risk assessment process using a uniform tool will be used with each participant to further identify risk and supports needed. The totality of the assessment process along with other evaluations, as needed, will be used to determine if the participants' needs can be met by the waiver.

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

to adjust the dollar amount.

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

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

The MR2 assessment process which documents not only the level of care, but provides a comprehensive medical evaluation and other information to help to determine the intensity of support needs as well as identifying risks. Each participant who is admitted into the waiver will also be assessed to determine level of support needs through the application of the North Carolina Support Needs Assessment (NC SNAP), which provides for a determination of intensity of support needs. In addition, a psychological evaluation, including adaptive functioning assessment, is required during the assessment process. The totality of this assessment process along with other evaluations, as needed, will be used to determine if the participant's.

Participants currently served under the #0429 Comprehensive waiver will initially be placed into either the #0662 Comprehensive waiver or the #0663 Supports waiver. The participants will be placed into the specific waiver that corresponds to their current services as outlined in their Plan of Care and corresponding individual budget reflected in a cost summary of services. The individual budget/cost summary used to determine entry into a specific waiver will not include one- time costs such as home modifications, adaptive equipment, vehicle modification, specialized equipment or other one- time costs. Each Local Management Entity is providing the state the cost summary information for each consumer which is based upon a 12 month cycle or the most recent Continued Need Review (CNR). There should not be any fair hearing issues due to the fact there will be no termination, reduction or suspension of periodic and ongoing services.

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2000
Year 2	3000
Year 3	4000

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes
Movement from the Piedmont Innovations Waiver

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Movement from the Piedmont Innovations Waiver

Purpose (*describe*):

For participants who move from the Piedmont Innovations waiver area in North Carolina to CAP MRDD waiver area.

Describe how the amount of reserved capacity was determined:

Based upon the historical data, capacity will be reserved for participants who no longer live in the Piedmont Innovations area and who move to the areas served in North Carolina by the CAP MRDD waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2
Year 3	2

Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

Select one:

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

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

The North Carolina General Assembly, in session law 2001-437, designated the local mental health authorities (Local Management Entities/LME) as the ‘locus of coordination’ for the provision of all publicly funded MH/DD/SAS services.

A portion of available slots that are allocated to the LME’s are allocated according to the population of the catchment area served by the LME. The remainder of the slots are put into a reserve pool. The reserve pool will be managed by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and will be used to allocate slots to individuals with urgent support needs once the Local Management Entity has exhausted their allocated slots.

The Local Management Entity serves as the single portal for the HCB service eligibility. A standardized prioritization tool has been developed for Local Management Entities to use to determine the support needs of the individuals requesting CAP-MR/DD funding. The tool prioritizes the needs of individuals for supports into two areas-Urgent and Routine. Urgent needs are categorized as individuals who are homeless, have documented incidents of abuse or neglect, or whose caregiver is in poor health. Urgent needs are addressed first.

The Local Management Entity is allocated a portion of the available slots three times a year. The Local Management Entity will use these slots to fill all urgent needs. If the Local Management Entity has more individuals with urgent needs than they have allotted slots, these individuals will be referred to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services will use a slot from the reserve pool. This procedure will assure that individuals with urgent needs will have first priority for slots no matter where they reside in the state. Remaining slots may be used by the Local Management Entity for individuals with routine needs.

Slots allocated remain with the individual no matter where in the service area they reside

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

Each LME will implement a uniform prioritization tool to assist in determining the utilization of waiver slots.

Individuals who seek CAP-MR/DD Waiver services are evaluated for their potential eligibility and then are prioritized according to urgency and need. This evaluation process includes assessment of needed services and potential risks that determine the intensity of service needs. Based on the outcome of this assessment, individuals are prioritized as having emergent (crisis), or routine needs based on the following criteria:

Emergent (Crisis)

Individuals who present with emergency/crisis needs are offered entrance to the waiver ahead of other individuals to the extent that capacity is available. The following are considered emergency/crisis situations.

- Homelessness or pending imminent homelessness with no viable housing alternative
- At significant risk of serious physical harm in current environment
- At significant risk of causing serious physical harm to others in current environment
- Requiring protection from confirmed abuse, neglect, or exploitation;
- Caregivers unable to provide adequate care due to caregivers' significantly impaired health as documented.

Routine Need:

Individuals who are not identified as being in crisis are considered to be routine requests. These individuals will be prioritized using a uniform prioritization tool. The prioritization tool is need based, but the length of time the applicant has been waiting for waiver services is factored into the prioritization.

Applicants are re-evaluated annually with respect to these criteria. As waiver funding becomes available, entrance to the waiver is offered first to individuals with emergent needs, and then to those applicants with routine needs. In the event two or more individuals are assessed to have the same urgency or intensity of needs, the date of application will determine which individual is offered waiver funding.

When reserved capacity is available, individuals who are transitioning from the Piedmont Innovations Waiver will receive priority consideration for these reserved slots. If reserved capacity is not available, individuals who are transitioning the Piedmont Waiver will be prioritized for entrance to the waiver based on the above uniform prioritization tool criteria.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- No
- Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

Individuals receiving under 42 CFR 435.135 (passalong).

Individuals receiving under 42 CFR 435.115 (e)(1) (Title IV-E adoptive and foster children)

Individuals who are receiving under 42 CFR 435.201 (a)(4) who are foster children.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- Directly by the Medicaid agency**

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

Specify the entity:

Initial level of care evaluation is conducted by clinical staff at the Murdoch Center; re-evaluations are conducted by the case manager.

- Other
- Specify:

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

Once Support Waiver funding/slot has been identified for an applicant, an MR2 documenting that the applicant meets the ICF-MR LOC is completed. Clinical staffs employed by DMH/DD/SAS make the final determination of level of care. Clinical staff includes a PhD level psychologist and Qualified Developmental Disabilities Professionals. Clinical staffs make determination of LOC on 100% of individuals for whom there is reasonable indication of need for services and for whom funding is available.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To be Medicaid certified at the ICF-MR LOC, the participant must:

Require ICF-MR level of care and;

Have a diagnosis of mental retardation OR a condition closely related to mental retardation as defined here.

A. Mental retardation is a disability characterized by significant limitations both in the intellectual functioning and in adaptive behavior as expressed in conceptual, social and practical adaptive skills. The disability originates before age 18. and/or

B. Persons with closely related conditions refer to individuals who have a severe, chronic disability that meets ALL of the following conditions:

1. It is attributable to:
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and
2. It is manifested before the person reaches age 22; and
3. It is likely to continue indefinitely; and
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.

The instruments/tools used to assess eligibility are the:

- MR2
- ICF-MR Level of Care evaluation form
- Current psychological evaluation and medical evaluation

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

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

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

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

- A continued need review (CNR) is completed annually for all participants by a Qualified Development Disabilities Professional (QP).

- LMEs are required by legislation to request LOC reviews for initial determination of ICF-MR LOC as well as for annual re-evaluation of LOC when there is a question of continuing eligibility. LMEs must sign all MR2s reflecting annual LOC review by the QP. If the LOC is questioned by the LME during this process there are procedures outlined in the CAP-MR/DD Manual reflecting a process of request for LOC review by clinical staff of Murdoch Center.

The statewide utilization review vendor also reviews the MR2 documenting LOC with the submission of the annual Person Centered Plan. The Person Centered Plan may not receive approval without the inclusion of the annual LOC review form, the MR2. If the LOC is questioned by the utilization review vendor at the time of the review of the Person Centered Plan the vendor may request a formal review of LOC through the LME. The LME would then submit the request for review of LOC to Murdoch Center clinical staff. Review of LOC by Murdoch Center may result in a decision that the individual does not meet the ICF-MR LOC, in which case a letter of denial is submitted to the consumer/legally responsible person with appeal rights.

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

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

Specify the other schedule:

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

Specify the qualifications:

Qualified Professionals providing the annual level of care reevaluation are case managers employed by agencies who contract with the Local Management Agencies (LME) or local county programs, to provide Case Management services. Individuals who perform reevaluations must meet the staffing requirements as outlined in the service definition for Case Management.

Case Managers are professionals whose education, skills, abilities, and experience enables them to perform the activities that comprise Medicaid case management services.

Qualified case managers shall meet the qualifications in (i) and (ii) as stated below:

- (i) Be a qualified Developmental Disabilities Professional (QDDP) as defined: An individual holding at least a baccalaureate degree in a discipline related to developmental disabilities and at least two full time years of supervised experience by a QDDP in working with individuals with mental retardation or who are otherwise developmentally disabled or hold a baccalaureate degree in a field other than one related to developmental disabilities and have three full time years of supervised QDDP experience in working with individuals with mental retardation or who are otherwise developmentally disabled; and (ii) Staff must successfully complete First Aid, CPR, and other trainings required by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, specific participant related competencies along with any required refresher courses. Staff must have a criminal background check. Staff must have a valid North Carolina driver's license, a safe driving record, an acceptable level of automobile liability insurance, and NC Health Care Registry check completed prior to working with this target

population.

The DHHS is developing Core Competencies that describes the specific training requirements of all staff. The Core Competencies will include training specific to the Level of Care process and the responsibilities of the case manager with this process.

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

After the initial evaluation, a re-evaluation of the LOC is completed annually during the individual's birthday month. Reevaluation of level of care is an integral part of case management services.

The following process for re-evaluation must be followed:

- A new MR2 is completed and signed by the case manager or a physician/licensed psychologist and the LME staff.
- The MR2 is typically signed during the birth month but may be signed no earlier than the month prior to the birth month.
- Completion of the MR2 documenting level of care must be completed annually.

The DMH/DD/SAS conducts reviews of local approval processes that include a review of timely completion of the MR2 and the level of care reevaluation. The Behavioral Health unit of DMA conducts quality assurance reviews that include a review of the application of eligibility criteria for individuals participating in the waiver and will monitor level of care re-determination. Should the review question the ICF-MR level of care, the LME will be notified so they can refer the case to Murdoch Center for a determination of level of care.

The waiver requires that Qualified Developmental Disabilities Professionals provide an annual re-determination of LOC. As a result, there is a need to provide greater assurance of the accuracy of those re-determinations. The DMH/DD/SAS in collaboration with DMA requires a process in which the LME will review a sample (5% or 30 cases whichever is less) of re-determination of LOC monthly to insure timeliness and accuracy. When issues arise related to LOC during this sampling process, LME's will be responsible, as a component of their current monitoring responsibilities, to address the issues with the specific provider agency for corrective action. The results of the LME audits will be reported to the DMH/DD/SAS quarterly. In addition, LMEs may request that Murdoch review an existing CAP-MR/DD recipient's ICF-MR LOC eligibility status. In addition to these processes for discovery and remediation, all case manager triggering a LOC review. Finally, the statewide utilization vendor will submit a quarterly report to the DMH/DD/SAS identifying individual's that received an annual LOC review as well as Person Centered Plan review and the timeliness of that process. When issues are noted with specific case management agencies, the LME through their regular monitoring process will be expected to address the issues with the provider agency through a corrective action process and follow up.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of each initial LOC evaluation must be maintained at the Murdoch Center for a minimum period of five years. Case Management agencies and LMEs are responsible for maintaining records of reevaluations for a minimum of five years for those individuals over the age of 18. For participants not over the age of 18, documents must be maintained until their 23rd birthday.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:

DMA reviews the proportion of applicants who have been enrolled in the waiver, who had an initial level of care evaluation. N= total # of applicants who had an initial LOC evaluation D= total # of applicants enrolled in the waiver

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME enrollment data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 300px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 300px;" type="text"/>

Performance Measure:

Proportion of LOC denials rendered by Murdoch Center and which the appeal of decision caused the LOC denial to be overturned. N= all appeals for denied LOC's that were overturned D= total number of denied LOC's that were appealed

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 150px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 200px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 150px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 150px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 200px;" type="text"/>	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Proportion of participants who have had the Continued Need Review completed by their birth month. N= Total number of who have had the Continued Need Review completed by their birth month D= All current participants who require a CNR and are still receiving services

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Manager CNR data

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Case Manager	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Proportion of LOC eligibility determination packets that were returned to the LME for incompleteness of documentation. N= Total number of LOC eligibility determination packets returned to the targeted case manager. D= Total number of applicants who had initial LOC evaluations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS data

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The proportion of applicants reviewed whose initial or subsequent LOC outcome was appropriately determined. N=Number of randomly selected waiver participants who do not have a diagnosis of mental retardation or an approved related condition D= Total number of PCPs reviewed by DMA

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by LME and case management agency.
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of applicants, who receive a waiver slot and an approved LOC, who begin receiving services within 30 days after being prioritized for a slot. N= total # of applicants who have an approved initial LOC evaluation D= total # of applicants who have an approved initial LOC evaluation and services were implemented within 30 days of the LOC approval.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME enrollment data

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

LME is Local Management Entity.

UR Vendor= Agency contracted by DMA to conduct Utilization Review.

Murdoch Center is an Operating Agency facility that determines LOC.

Annually: State fiscal year (July 1-June 30)

a.i.a.1, a.i.a.2:

Currently the LME prioritizes applicants using a uniform Prioritization process. All applicants, must have an approved LOC determination to establish if the applicant meets ICF-MR/DD level of care criteria before CAP-MR/DD waiver services may be implemented.

The case manager submits the required LOC determination packet (MR-2 and a diagnostic assessment by a psychologist) to Murdoch Center (a DMH/DD/SAS Developmental Disability Center). The Murdoch Center LOC staff reviews the documents using the processes and instruments described in the approved CAP-MR/DD waiver to make a LOC determination. If the documents indicate the applicant meets the criteria for CAP-MR/DD waiver services, the LOC is approved.

The approved initial LOC determination packet are compared to the names of the prioritized applicants to make sure all prioritized applicants receive an LOC evaluation. The LOC reviewer maintains a database of reviewed, denied and approved applicants, their case managers and LMEs. A monthly report is generated as well as an annual aggregate report.

a.i.b.1, a.i.b.2:

The PCP must be updated annually for all enrolled CAP-MR-DD waiver participants. The annually updated PCP is referred to as the Continued Need Review (CNR). The case manager submits the CNR to the UR vendor who is responsible for its review and approval. Using the same process as the UR vendor, the DMH/DD/SAS reviews all PCPs for the Participants who self direct.

The UR vendor and DMH/DD/SAS have ten (10) days to complete the reviews. Data will be generated by DMA on the CNRs

due each month, CNRs approved/denied, and CNRs not submitted according to the waiver timeline, grouped by the case manager and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

a.i.c.1, a.i.c.2, a.i.c.3, a.i.c.4:

The DMA, and DMH/DD/SAS conduct a monthly review of PCPs that includes a review of the participant's need for waiver services and evidence in the PCPs that services and supports provide for the participant's health safety and well being (e.g. risk assessment, crisis plan, back up plan). The plans must include current MR-2s and diagnostic assessments.

a.i.c.4: Waiver services must be implemented within 30 days following the prioritization of a waiver applicant. When reviewing PCPs, the LME ,DMA reviewer, and DMH/DD/SAS reviewers monitor the adherence to required timelines.

b. Methods for Remediation/Fixing Individual Problems

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

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the targeted case manager to have the initial LOC determination process initiated.

If the review process indicates the initial LOC determination packets are incomplete or need additional information, the Murdoch Center reviewer returns the packet to the LME who returns the packet to the case manager along with a request to amend the packet so that the review may be completed. The case manager has fifteen (15) days to return the amended packet to the reviewer. The reviewer has five (5) days to complete the review process. Murdoch Center maintains a database of these LOC evaluations, issues encountered and timeliness of submission and resubmission. The database also reflects the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies (DMA, DMH/DD/SAS).

The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team. A CAP-MR/DD Waiver Database is being developed to maintain the data from all waiver-related reviews. This database will facilitate the aggregation and analysis of the data.

If the DMH/DD/SAS reviewers find issues with the CNR, they contact the case manager and request that corrective action be taken. The case manager has five (5) days to re-submit the CNR. DMA conducts approximately 40 quality assurance reviews of PCPs each month. This review involves the evaluation of the participant's need for waiver services.

If issues are identified, the reviewer alerts DMH/DD/SAS, which contacts the case manager to request corrections. Both agencies maintain a database of the results of these PCP reviews, including issues encountered and timeliness of submission and resubmission. The databases also reflect the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

If it is discovered that a participant does not meet LOC criteria, the DMA notifies the DMH/DD/SAS, which contacts the LME who contacts the case manager to re-submit an updated LOC determination packet, so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The case manager informs the participant of their appeal rights included in the DHHS appeals process.

If it is discovered that a participant does not meet LOC criteria, the DMA will also provide technical assistance to the LOC reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the case manager to have the initial LOC evaluation started.

If it is discovered that a participant has no CNR by their birth month, the UR vendor notifies the LME and the LME contacts the case manager to have the CNR completed. In order to continue provision of services, the case manager must request and receive approval from the UR vendor, for services to continue until the CNR is completed.

If it is discovered that a participant does not meet ICF-MR/DD LOC criteria, the DMA notifies the DMH/DD/SAS who contacts the LME who contacts the case manager to re-submit an updated LOC determination packet, so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The participant may choose to initiate the DHHS appeals process.

If it is discovered that a participant does not meet LOC criteria, DMA will also provide technical assistance to the Murdoch Center reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

ii. Remediation Data Aggregation

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

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

	<i>that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Information regarding waiver providers, participants and services are currently available in multiple data systems throughout the DMH/DD/SAS. An electronic database will be developed by the DMH/DD/SAS to bring together waiver-specific data into one location that can be accessed by all members of the DMH/DD/SAS waiver staff who generate, collect and review waiver data. The database will be operational by December 31, 2009.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Each waiver participant will be informed by the case manager of the choice of either institutional or home and community-based services at the time of eligibility screening for home and community based waiver services and prior to enrollment into the waiver program. In addition, participants will be provided information regarding feasible alternatives under the waiver during this time in order that the individual may make an informed choice.

Feasible alternatives means the types of waiver services that would be available to the individual to address the person's assessed needs, subject to the development of the person's Person Centered Plan. Documentation of the choice of home and community-based services over institutional services is documented on the Person Centered Plan.

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

Copies of Freedom of Choice forms are maintained by the case management agency.

Appendix B: Participant Access and Eligibility

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

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

The North Carolina Department of Health and Human Services (DHHS) has implemented a language access policy to ensure that individuals with limited English proficiency (LEP) have equal access to benefits and services for which they may qualify from entities receiving federal financial assistance. The policy applies to the North Carolina Department of Health and Human Services, all Divisions/Institutions within DHHS, and all programs and services administered, established or funded by the Department, including subcontractors, vendors, and sub-recipients. The policy requires all Divisions and Institutions within DHHS and all local entities, including Area Mental Health, Developmental Disabilities and Substance Abuse Programs, to draft and maintain a Language Access Plan. The Plan must include a system for assessing the language needs of LEP populations and participant LEP applicants/recipients; securing resources for language services; providing language access services; assessing and providing staff training; and monitoring the quality and effectiveness of language access services. Local Management Entities must ensure that effective bilingual/interpretive services are provided to serve the needs of the non-English speaking populations at no cost to the recipient. Local Management Entities must also provide written materials in languages other than English where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Day Supports
Statutory Service	Home and Community Supports
Statutory Service	Personal Care
Statutory Service	Respite
Statutory Service	Supported Employment
Other Service	Augmentative Communication Devices
Other Service	Behavior Consultation Service
Other Service	Crisis Respite
Other Service	Crisis Services
Other Service	Home Modifications
Other Service	Individual and Caregiver Training
Other Service	Individual Goods and Services (self direction only)
Other Service	Long Term Vocational Supports
Other Service	PERS (Personal Emergency Response System)
Other Service	Specialized Consultative Services
Other Service	Specialized Equipment and Supplies
Other Service	Transportation
Other Service	Vehicle Adaptation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

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

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

Service Definition (Scope):

Adult Day Health service is a service furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of this service shall not constitute a “full nutritional regiment” (3 meals per day). The service is provided in a certified Adult Day Health Care facility.

This service is for adults who are aged, disabled, and handicapped that need a structured day program of activities and services with nursing supervision. It is an organized program of service provided during the day in a community group setting for the purpose of supporting an adult’s independence, and promoting social, physical, and emotional well being. Services must include health services and a variety of program activities designed to meet the participant’s needs and interests.

The cost of transportation is not included in the rate paid to providers of Adult Day Health services.

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

This service may not be provided at the same time of day that a participant receives: Home and Community Supports, Individual and Caregiver Training, Personal Care Services, Respite Care, Specialized Consultative Therapy, Supported Employment, Transportation.

It may not be provided on the same day as Day Supports

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Individual

Provider Type:

Adult Day Health Provider

Provider Qualifications

License (specify):

Adult Day Health Services must have a certification by the NC Division of Aging and Adult Services

Certificate (*specify*):

Other Standard (*specify*):

Provider must be endorsed by the LME as a provider of Adult Day Health Services.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Adult Day Health Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Day Habilitation ▼

Alternate Service Title (if any):

Day Supports

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

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

Service Definition (Scope):

Day supports provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which take place in a non-residential setting, separate from the home or facility in which the participant resides.

Day supports shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Person Centered Plan. In addition, habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

This service meets the day programming needs of participants who choose to attend or receive services provided by a licensed facility, such as an adult day vocational program (ADVP) or Developmental Day. Community activities that originate from a licensed day facility will be provided and billed as Day Supports. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Day Supports may include prevocational activities. The following criteria differentiate between prevocational and vocational services.

- Prevocational Services are provided to persons who are not expected to join the general work force or participate in a transitional sheltered workshop within one year of service initiation.
- If compensated, individuals are paid at less than 50% of the minimum wage.
- Services include activities that are not directed at teaching job-specific skills but at underlying habilitative goals (e.g.: attention span, motor skills, attendance, task completion).

Day Supports not may not be used for the provision of vocation services (e.g., sheltered work performed in a facility).

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

Day supports provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which take place in a non-residential setting, separate from the home or facility in which the participant resides.

Day supports shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Person Centered Plan. In addition, habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

This service meets the day programming needs of participants who choose to attend or receive services provided by a licensed facility, such as an adult day vocational program (ADVP) or Developmental Day. Community activities that originate from a licensed day facility will be provided and billed as Day Supports. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Day Supports may include prevocational activities. The following criteria differentiate between prevocational and vocational services.

- Prevocational Services are provided to persons who are not expected to join the general work force or participate in a transitional sheltered workshop within one year of service initiation.
- If compensated, individuals are paid at less than 50% of the minimum wage.
- Services include activities that are not directed at teaching job-specific skills but at underlying habilitative goals (e.g.: attention span, motor skills, attendance, task completion).

Day Supports not may not be used for the provision of vocation services (e.g., sheltered work performed in a facility).

Service Limitation:

This service may only be provided by a licensed day facility and is inclusive of transportation to and from the participant's primary residence, the licensed day facility, and/or the community. Travel time is not actual service time and therefore actual billing for the service begins after the person reaches the site; the travel time is addressed through the rate established for the service definition.

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

This service may not be provided at the same time of day that a person receives: Home and Community Supports, Individual and Caregiver Training, Personal Care Services, Respite Care, Specialized Consultative Services, Supported Employment, Transportation or one of the regular Medicaid services that works directly with the person, such as Personal Care Services, Home Health Services, MH/DD/SAS Community Services, or individual therapies. It may not be provided on the same day as Adult Day Health.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Before and After School Day Care Programs
Agency	Licensed Developmental Day Programs
Agency	Adult Day Care Program
Agency	Day Support Provider
Agency	Licensed Day Care Programs

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Before and After School Day Care Programs

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Before and After School Day Care Programs operated by NC Public School System and qualified by LMEs

Provider must be endorsed by the LME as a provider of Day Supports.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided

according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Day Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial Endorsement and re-endorsement at least every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Licensed Developmental Day Programs

Provider Qualifications

License (specify):

Licensed Developmental Day

Programs-.2200-.2400

G.S. 122C

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Day Supports.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.

- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Day Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Adult Day Care Program

Provider Qualifications

License (specify):

Adult Day Care Programs

N.C. G.S. 122C

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Day Supports.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED

- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Day Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Day Support Provider

Provider Qualifications

License (specify):

NC G.S. 122 C

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Day Supports.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200

- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Day Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Licensed Day Care Programs

Provider Qualifications

License (specify):

N.C.G.S. 122C

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Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Day Supports.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Day Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three year thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Home and Community Supports

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

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

Service Definition (Scope):

Home and Community Supports is a habilitation service. Home and Community Supports enables the individual to acquire and maintain skills that will allow him/her to function with greater independence in the community. Home and community supports provide habilitation, training and instruction coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the participant's day. Support combined with supervision of the participant's activities to sustain skills gained through habilitation and training is also an acceptable goal of home and community supports. This service is not to be used for participants receiving Residential Supports

Home and Community Supports consist of an integrated array of individually designed habilitative services and supports that are described in the Person Centered Plan. This service is distinctive from personal care services by the presence of training activities in combination with support, supervision, and monitoring as described in the Person Centered Plan. This service can be delivered in a participant's private home or in a variety of community settings to which the participant chooses to attend

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

Additionally, this service is not to be used at the same time of day as Adult Day Health, Day Supports, Personal Care, Respite, Specialized Consultative Therapy, Transportation, or Individual and Care Giver Training

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Provider (self direction only)
Agency	Home and Community Support Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home and Community Supports

Provider Category:

Individual

Provider Type:

Independent Provider (self direction only)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Home and Community Support Service.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED

- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license a safe driving record and an acceptable level of automobile liability insurance.

Home and Community Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

Before hiring and annually thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Home and Community Supports

Provider Category:

Agency

Provider Type:

Home and Community Support Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Home and Community Support Service.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200

- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Home and Community Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

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

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Personal Care Services under North Carolina state plan differ in service definition or provider type from the services to be 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 participant participation is non-habilitative and describes the flexibility of activities that may encourage the participant to maintain skills gained during active treatment and/or habilitation while also providing supervision for independent activities of the participant. This service may include preparation of meals, but does not include the cost of the meals themselves. Engaging participant in utilizing skills gained during active treatment and/or habilitation is key and may be provided outside of the individual’s residence.

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

Enhanced Personal Care is intended for participants receiving waiver funding who have intense medical or behavioral needs. It is not a habilitative service but includes the same activities and functions as Personal Care Services. This service is intended 1) for participants who require the expertise and/or supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) due to the complexity or critical nature of the activities provided or 2) for participants with complex or extreme behaviors that are difficult to assess or effectively treat and therefore require a comprehensive behavioral plan. Such intense medical or behavioral needs must be identified by the NC-SNAP and the Person Centered Plan must provide clear documentation and justification of the need for Enhanced Personal Care. Enhanced Personal Care tasks may require some degree of decision making which could affect the health or safety of the participant on the part of the direct care staff providing the service. Direct care staff must receive on going training and supervision in the tasks to be completed. Specific training must be documented in the Person Centered Plan and be reflected in the personnel file of the direct staff member.

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

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 alternative family living (AFL) homes, licensed foster care homes, or unlicensed alternative family living homes serving one adult can not bill for any aspect of this service nor any other related state plan personal care service.

This service may not be provided on the same day that the participant receives regular Medicaid Personal Care, a Home Health Aide visit, or another substantially equivalent service. This service may not be provided at the same time of day that a participant receives: Adult Day Health, Day Supports, Home and Community Supports, specialized Consultative Therapy, Respite Care, Supported Employment, or Transportation. This service may not be used by participants residing in an out of home placements such as Licensed Residential settings or unlicensed AFLs.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Self Employed Individual (Self Direction Only)
Agency	Home Health Agency
Agency	Personal Care Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Personal Care Self Employed Individual (Self Direction Only)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Approved by Financial Management

Provider must be endorsed by the LME as a provider of Personal Care Services.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED. Staff who do not have a GED or a High School Diploma but were providing CAP-MR/DD personal care services prior to the implementation of this waiver will have a transition period of 18 months to meet the minimum education requirement. 18 months after the implementation of this waiver all staff who provide personal care services will meet the minimum education requirement of a GED or High School Diploma.
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Personal Care Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Manager

Frequency of Verification:

Prior to hiring and annually thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Licensed by the Division of Health Service Regulation as a Home Care Agency

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Personal Care Services.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED. Staff who do not have a GED or a High School Diploma but were providing CAP-MR/DD personal care services prior to the implementation of this waiver will have a transition period of 18 months to meet the minimum education requirement. 18 months after the implementation of this waiver all staff who provide personal care services will meet the minimum education requirement of a GED or High School Diploma.
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Personal Care Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial enrollment and re-endorsement at least every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Care Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Personal Care Services.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED. Staff who do not have a GED or a High School Diploma but were providing CAP-MR/DD personal care services prior to the implementation of this waiver will have a transition period of 18 months to meet the minimum education requirement. 18 months after the implementation of this waiver all staff who provide personal care services will meet the minimum education requirement of a GED or High School Diploma.
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Personal Care Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the

Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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

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

Service Definition (Scope):

Service Definition (Scope):

Respite Care is a service that provides periodic relief for the family or primary caregiver as detailed in the Person Centered Plan. In order to be considered the primary care giver, a person must be principally responsible for the care and supervision of the participant, and must maintain their primary residence at the same address as the covered participant. This service may be provided in the participant's home or in an out-of-home setting. There must be clear justification outlined within the Person Centered Plan for Respite Care Services. Specified training requirements for direct care staff must be clearly documented within the Person Centered Plan for the task that will be performed for Respite Care services

Enhanced Level of Respite is for participants who have behavioral or medical needs that require staff that are specifically trained to conduct personal care tasks or behavioral procedures. A participant receiving enhanced personal care has needs that require:

Additional skill level of staff

Additional training so that a higher level of decision can be made achieved

Additional supervision

Individuals with extreme medical conditions would need staff supervision by an RN or an LMN

Individual should have a Behavior Plan in place if there are identified intense behavior issues

Nursing Level of Respite is for participant's who have medical needs that require nursing staff to conduct respite services. Nursing level services require a physician's order (MD, NP, PA)

Nursing Level of Respite is for participant's who have medical needs that require nursing staff to conduct personal care services.

Respite Care- Institutional is respite provided in an ICF-MR bed in a State regional MR facility. This type of respite is generally used when community-based services are not available to care for the person.

There must be clear justification outlined within the Person Centered Plan for the level of Respite Service needed. Specified training requirements for direct care staff and supervision requirements must be clearly documented in the Person Centered Plan.

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

- Private home respite services serving participants outside their private homes are subject to licensure under G. S. 122C Article 2

when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month;

- Respite may not be used as a scheduled daily service;
- Respite may not be used for participants who are living alone or with a roommate;
- Staff sleep time is not reimbursable;
- Respite services are only provided for the participant; other family members, such as siblings of the participant may not receive care or supervision from the provider while Respite care is being provided/billed for the participant;
- Respite is not provided by any person who resides in the participant's primary residence;
- The cost of 24 hours of respite care in the community cannot exceed the per diem rate for the cost of Institutional Respite Services per day.
- Federal financial participation will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.
- Respite will be provided in the following locations:
 - o participant's home or place of residence
 - o foster home
 - o licensed respite facility
 - o other community care residential facility approved by the state that is not a private residence including;
 - alternative family living arrangement
 - certified respite provider's home

This service may not be provided at the same time of day that a participant receives: Personal Care, Adult Day Health, Day Supports, Home and Community Supports, Specialized Consultative Therapy, Supported Employment, or Transportation OR one of the regular Medicaid services that works directly with the participant, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	State Entity
Agency	Respite Provider
Individual	Respite - Self Employed Individual (Self Direction ONLY)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

State Entity

Provider Qualifications

License (*specify*):

122C as appropriate

Certificate (*specify*):

Other Standard (*specify*):

122 C as appropriate
Entity operates under DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

LME

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider

Provider Qualifications

License (specify):

Private home respite services serving participants outside their private homes are subject to licensure under G. S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month. A respite facility licensed by DFS in accordance with N.C.G.S. 122C

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Respite Provider.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED. Staff who do not have a GED or a High School Diploma but were providing CAP-MR/DD respite care services prior to the implementation of this waiver will have a transition period of 18 months to meet the minimum education requirement. 18 months after the implementation of this waiver all staff who provide respite care services will meet the minimum education requirement of a GED or High School Diploma.
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Respite Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of

meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Respite - Self Employed Individual (Self Direction ONLY)

Provider Qualifications

License (specify):

G.S.122C , as applicable

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Respite.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED. Staff who do not have a GED or a High School Diploma but were providing CAP-MR/DD respite care services prior to the implementation of this waiver will have a transition period of 18 months to meet the minimum education requirement. 18 months after the implementation of this waiver all staff who provide respite care services will meet the minimum education requirement of a GED or High School Diploma.
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Respite Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

An RN or LPN must provide Nursing Respite.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

At hiring and yearly thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

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

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

Service Definition (Scope):

Supported Employment (individual) services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports and who, because of their disabilities need support, to perform in a regular work setting. Supported employment may provide assistance with choosing, acquiring, and maintaining a job for participants ages 16 and older for whom competitive employment has not been achieved and /or has been interrupted or intermittent.

When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment may assist participants in the achieving self-employment through the operation of a business.

This assistance consists of: (a) aiding the participant to identify potential business opportunities; (b) assistance in following a business plan, (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing support, counseling and guidance once the business has been launched.

Transitional Work Services (Supported Employment Group) consist of supporting participants in transition to integrated, competitive

employment through work that occurs in a location other than a licensed facility. Transitional work service options include, but are not limited to: mobile work force, work station in industry, affirmative industry, and enclave. A Mobile Work Force uses teams of workers, supervised by a training/job supervisor, who conduct service activities away from an agency or facility. The provider agency contracts with an outside organization or business to perform maintenance, lawn care, janitorial services, or similar tasks and the participants are paid by the provider.

A Work Station in Industry involves participant or group training of participants at an industry site. Training is conducted by a provider training/job supervisor or by a representative of the industry, and is phased out as the participant(s) demonstrate job expertise and meet established production rates.

Affirmative Industry is defined as an integrated business, where disabled and non-disabled employees work together to carry out the job functions of the business. Enclave is defined as a business model where participants with disabilities are employed by a business/industry to perform specific job functions while working alongside workers who are non-disabled.

Documentation will be maintained in the file of each provider agency specifying that this service is not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973, or Participants with Disabilities Education Act (20 U.S.C. 1401 et seq.) for this participant

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

FFP can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for training that are not directly related to a participant’s supported employment program.
- This service is not available at the same time of day as Day Supports, Home and Community Supports, Respite or one of the State Plan Medicaid services that works directly with the participant.
- Transportation will be provided between the individual’s place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation service.
- Supported Employment must be reviewed every six months by the Case Manager and team with continuing participation contingent upon achievement of outcomes in the individual’s Person Centered Plan.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Provider Agency

Provider Qualifications

License (*specify*):

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Supported Employment

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Supportive Employment Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

statute.

Service Title:

Augmentative Communication Devices

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

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

Service Definition (Scope):

Augmentative Communication devices are necessary when normal speech is non-functional and/or when physical impairments make a gestural system impossible and/or ineffective. An aided system requires access to a symbolic system that is separate from the body. The selection of devices (and training outcomes for those devices) must be specific and based on age, cognitive ability, fine and gross motor mobility, environmental need and the presence or absence of sensory impairment. These devices are recommended by a Speech Language Pathologist licensed to practice in the state of North Carolina and documented in the Person Centered Plan as necessary to meet the needs of the participant. The Person Centered Plan also specifies who and how the individual and/or his/her family/caregiver will be trained on the use of the equipment.

This service also covers technical assistance provided to participants in the selection and use of augmentative communication devices by qualified augmentative communication technology professionals. This assistance may not duplicate evaluation and services provided by a licensed Speech Language Pathologist, Occupational Therapist, and/or Physical Therapist. Technical assistance in the selection of augmentative communication devices will be billed through the LME under the Augmentative Communication definition. Service and repair of purchased equipment is included when not covered by warranty.

The hardware and software needed to augment communication is divided into the following categories:

- Low technology and clinician made devices
- High technology, commercially available dedicated devices and systems
- Standard computer/monitors and operating peripherals
- Computer-driven devices, operating peripherals and printers when there is substantial documentation that a computer will meet the needs of the participant more appropriately than a Communication Board
- Communication Board Mounting Kits
- Overlay kits and accessories
- Switches/pointers/access equipment—all types, standard and specialized
- Keyboard/voice emulators/key guards
- Voice synthesizers
- Carry cases
- Supplies (battery, battery charger)
- Artificial larynges

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

The cost of Augmentative Communication devices shall not exceed \$10,000 per waiver year per participant.

Augmentative communication devices cannot be purchased for use in the school system.

The service may not be used to purchase cameras.

Augmentative communication devices will be a covered waiver expense when not coverable under the Medicaid Durable Equipment Guidelines nor available for a child under the age of 21 as an EPSDT item. EPSDT covered services only refer to those provided under State Medicaid and NOT to Augmentative Communication devices covered only in the waiver.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
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Agency	Specialized Vendor
Agency	Commercial/Retail Businesses

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Augmentative Communication Devices

Provider Category:

Agency

Provider Type:

Specialized Vendor

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Augmentative Communication Devices

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Behavior Consultation Service

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

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

Service Definition (Scope):

This service provides assessment, treatment, consultation, support and training in behavioral procedures and techniques that are designed to decrease maladaptive behaviors while increasing positive alternative behaviors. This service is intended to assist participants in acquiring and maintaining the skills necessary to live independently in their communities and avoid institutional placement. Behavioral consultants will provide assessment and treatment of participants and support, training and consultation to staff and/or family members or primary caregivers who support participants who exhibit maladaptive behavior that is often dangerous and possibly life-threatening. These behaviors are often complicated by medical or mental health factors.. Consultation may include assessing behavior, designing a behavior intervention program, monitoring the plan and training staff, family members or primary caregivers on how to implement the plan.

A Behavioral Consultant II can provide consultation, support and training in procedures and techniques that are designed to decrease maladaptive behaviors while increasing positive alternative behaviors. However, when a participant's behavior includes severe aggression, self-injurious behavior and other potentially life-threatening behavior, a Behavioral Consultant III must develop and monitor the behavior program due to the greater degree of expertise and experience required. A Behavioral Consultant II can also provide consultation and treatment for the full array of services described in the above service definition even in the absence of severe aggression, self-injurious behavior, and other life-threatening behavior.

Staff Qualifications:

Behavior Consultation II

Individuals providing Behavior Consultation Level II must meet the following staffing requirements:

- Meet the requirements of a licensed psychologist or licensed psychological associate in the state of North Carolina AND
- Be a Board Certified Behavior Analyst (BCBA) or have at least two years of supervised experience in conducting functional behavior assessments as well as the development and monitoring of behavior intervention plans. AND
- Have at least two years experience providing behavioral assessments, consultation and treatment to persons who have intellectual and developmental disabilities and who exhibit severe maladaptive behaviors.

Behavior Consultation III:

Individuals providing services at the Behavior Consultation III level must meet the following staffing requirements:

- Be a licensed psychologist or licensed psychological associate in the state of North Carolina AND
- Be a Board Certified Behavior Analyst (BCBA) or have at least two years of supervised experience in conducting functional behavior assessments as well as developing and monitoring behavior intervention plans. AND
- Have at least five years experience providing behavioral assessment, consultation and treatment to persons who have intellectual and developmental disabilities and who exhibit severe aggression, self-injurious behavior and other potentially life-threatening behavior.

Location/Service Limitation:

It is expected that the services of a Behavioral Consultant II or III are to be provided in the participant's residence, in the setting where the maladaptive behavior is occurring or in the consultant's office.

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

The services of a Behavior Consultant II OR Behavioral Consultant III are limited to a combined 200 hours per waiver year.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Consultation Service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Consultation Service

Provider Category:

Agency

Provider Type:

Behavior Consultation Service

Provider Qualifications

License (specify):

Staff Qualifications:

Behavior Consultation II

Individuals providing Behavior Consultation Level II must meet the following staffing requirements:

- Meet the requirements of a licensed psychologist or licensed psychological associate in the state of North Carolina AND

- Be a Board Certified Behavior Analyst (BCBA) or have at least two years of supervised experience in conducting functional behavior assessments as well as the development and monitoring of behavior intervention plans. AND

- Have at least two years experience providing behavioral assessments, consultation and treatment to persons who have intellectual and developmental disabilities and who exhibit severe maladaptive behaviors.

Behavior Consultation III:

Individuals providing services at the Behavior Consultation III level must meet the following staffing requirements:

- Be a licensed psychologist or licensed psychological associate in the state of North Carolina AND

- Be a Board Certified Behavior Analyst (BCBA) or have at least two years of supervised experience in conducting functional behavior assessments as well as developing and monitoring behavior intervention plans. AND

- Have at least five years experience providing behavioral assessment, consultation and treatment to persons who have intellectual and developmental disabilities and who exhibit severe aggression, self-injurious behavior and other potentially life-threatening behavior.

Certificate (specify):

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Other Standard (specify):

Behavioral Consultative Services must be delivered by practitioners employed by mental health, developmental

disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within two years of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Crisis Respite

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

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

Service Definition (Scope):

Crisis Respite is a short term service designed for the participant experiencing a crisis for which a period of structured support and/or programming is required. Crisis Respite may be used when a participant cannot be safely supported in the home due to his/her behavior and implementation of formal behavior interventions have failed to stabilize the behaviors and/or all other approaches to insure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver participants who are unable to access regular respite due to the nature of their behaviors. The service takes place in a licensed respite home.

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

- Crisis Respite may only be authorized for up to 30 calendar days per plan year.
- Crisis Respite is as 24 hour a day service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Respite

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Respite

Provider Category:

Agency

Provider Type:

Crisis Respite

Provider Qualifications

License (specify):

NC GS 122-C

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Crisis Respite

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Crisis Respite Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one

of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Crisis Services

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

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

Service Definition (Scope):

Crisis Services provide one additional staff person, who is trained in behavior techniques, the participant's Person Centered Plan and the crisis plan, to provide services for the waiver participant, as needed during an acute crisis situation so that the recipient can continue to participate in his/her daily routine and/or residential setting without interruption. Crisis Services is an immediate intervention available, 24 hours per day, 7 days per week to support other direct care staff, family members or primary caregivers. By providing this service, an imminent institution admission may be avoided while protecting the person from harming themselves or others. It is appropriate to provide such support during periods of time in which the person is presenting episodes of dangerous, and potentially life threatening behaviors that require specialized staff intervention. Crisis Services staff will support the implementation of the crisis intervention component/crisis plan of the formal behavior intervention program developed by a licensed psychologist under the definition of Behavior Consultation. After any crisis event it is expected that recommendations and changes as needed be made to the intervention program and crisis plan within five business days. After the tenth day the team will reconvene to determine what additional steps need to be taken to de-escalate the crisis or prevent the crisis from reoccurring.

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

Crisis Services may be authorized for periods of up to 15 calendar day increments. Crisis services can not exceed 2016 hours for the waiver year.

This service may not duplicate Behavior Consultation, level 1-3.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**

Provider managed

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Services

Provider Category:

Agency

Provider Type:

Crisis Services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must be endorsed by the LME as a provider of Crisis Service Provider.

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license, a safe driving record and an acceptable level of automobile liability insurance.

Crisis Service Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

Home Modifications

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

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

Service Definition (Scope):

Home Modifications includes equipment and physical adaptations to the participant’s home that are required by his/her needs as documented in the Person Centered Plan, as necessary to ensure the health, safety and welfare of the participant; enable the participant to function with greater independence in the home; and are of direct and specific benefit due to the participant’s disability. Home Modifications are cost effective compared to the provision of other services that would be required in an inaccessible environment. The service will reimburse the purchase, installation, maintenance and repair of Home Modifications. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item only after coverage of the warranty is explored.

Home Modifications will only be provided when the modification is necessary to meet the needs of the participant and prevents institutionalization. All services shall be provided in accordance with state or local building codes and Americans with Disabilities Act (ADA) requirements.

Home modifications include:

- Installation, maintenance and repairs of ramps, grab bars and handrails as well as portable ramps
- Widening of doorways/passageways for handicap accessibility
- Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved participants, sink modifications, toilet modifications, water faucet controls, floor urinal adaptations, plumbing modifications, and turnaround space modifications
- Bedroom modifications to accommodate hospital beds and/or wheelchairs
- Thermostats, shelves, closets, sinks, counters, cabinets and doorknobs
- Shatterproof windows
- Floor coverings for ease of ambulation
- Modifications to meet egress regulations
- Alarm systems/alert systems including auditory, vibratory, and visual to ensure the health, safety, and welfare of the participant (includes signaling devices for persons with hearing and vision loss)
- Fences to ensure the health, safety and welfare of an ambulatory waiver participant who lives in a private home and does not receive

paid supervision for 10 hours per day or more

- Video cameras to ensure the health, safety, and welfare of a waiver participant who must be visually monitored while sleeping for medical reasons, and who resides in a private home without paid supervision during sleep hours
- Porch or stair lifts
- Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that could be removed and taken to a new location that are used inside the participant's home
- Stationary/built in therapeutic table
- Weather protective modifications
- Fire safety adaptations

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

- Modifications that add to the total square footage of the home are excluded from this benefit.
- Home modifications can only be provided in the following settings:
 1. Dwelling where the waiver participant resides that is owned by the participant or the family.
 2. In rented residences when the modifications are portable.
- This service cannot be used to purchase locks.
- The total cost of Home Modifications cannot exceed \$15,000 over the duration of this waiver (3 years).

It is the responsibility of the case manager to track the cost of Home Modifications billed and paid for during a plan year, in order not to exceed the total amount of \$15,000 over 3 years. Costs that were not paid during one waiver year must be added to the cost summary for the next waiver year.

The service reimburses for the purchase, installation, maintenance, and repair of environmental modifications and equipment. Materials used shall be the most economical available to meet the purposes of the modification. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item.

Home Modifications can only be provided as a waiver service when they are documented in the Person Centered Plan as necessary to meet the needs of the recipient, prevent institutionalization and payment is not available as part of a Medicaid State Plan option.

All services shall be provided shall be justified in the PCP as necessary and that services shall be provided in accord with applicable State or local building codes. in accordance with applicable State or local building codes

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Businesses
Agency	Specialized Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License (*specify*):

Applicable state/local business license

Certificate (*specify*):

Other Standard (specify):

All services are provided in accordance with applicable State or local building codes and other regulations.
All items must meet applicable standards of manufacture, design, and installation

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial use and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Specialized Vendors

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

All services are provided in accordance with applicable State or local building codes and other regulations.
All items must meet applicable standards of manufacture, design, and installation

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial use and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual and Caregiver Training

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

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

Service Definition (Scope):

Individual Caregiver Training and Education includes training and counseling services for the participant and/or family members of the participant. The purpose of this service is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of the developmental disability upon the participant and his/her family, provide information about community integration options and strategies, provide education and training on intervention strategies, and provide education and training on the use of specialized equipment and supplies. Updates are included to maintain the participant safely at home.

For purpose of this service “family” is defined as the people who live with or provide care to the participant receiving waiver services, and may include a parent, spouse, children, relatives, foster family, guardians or in-laws. “Family” does not include individuals who are employed to care for the participant. All family training will include outcomes that are documented in the participant’s Person Centered Plan. The service includes conference registration, and enrollment fees for classes. Travel to conferences will be reimbursed for waiver participants. Conference registration and enrollment for classes billed through the LME using the LME’s business procedures. Outcomes related to conferences and classes must be clearly outlined in the Person Centered Plan.

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

Individual Caregiver Training and Education excludes training furnished to family members through Specialized Consultative Services.

The service is limited to a maximum expenditure of \$1500 per waiver year per person which includes a maximum of \$1000 for conference registration, travel to conferences for waiver participants, and enrollment fees for classes.

Individuals who are paid service providers are excluded from this service.

Participants receiving this service may not receive the following services at the same time of day as: Adult Day Health, Day Supports, Home and Community Supports, Personal Care, Respite, Supported Employment, or Specialized Consultative Therapy.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual (self direction only)
Agency	Educational and Conference Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Individual and Caregiver Training

Provider Category:

Individual

Provider Type:

Individual (self direction only)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Worker Qualifications: Must have expertise as appropriate,

in the field in which the training is being provided. Driving record must be checked if providing transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Individual and Caregiver Training

Provider Category:

Agency

Provider Type:

Educational and Conference Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Worker Qualifications: Must have expertise as appropriate, in the field in which the training is being provided. Driving record must be checked if providing transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Goods and Services (self direction only)

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

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

Service Definition (Scope):

Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the

Medicaid State Plan that addresses an identified need in the Person centered plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; and/or increase the person's safety in the home environment; and, the individual does not have the funds to purchase the items or service. Individual Goods and Services are purchased from the individual's self-directed budget. As a Medicaid funded service, this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60.

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

The cost of Individual Goods and Services for each participant cannot exceed \$5000 annually.

Individual Goods and Services is available only to those participant who self direct.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Individual Goods and Services (self direction only)

Provider Category:

Individual

Provider Type:

Individual Providers

Provider Qualifications

License (*specify*):

As appropriate to service purchased

Certificate (*specify*):

Other Standard (*specify*):

Must be part of Person Centered Plan

If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid

agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Long Term Vocational Supports

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

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

Service Definition (Scope):

Long Term Vocational Supports provide assistance with maintaining a job for participants who no longer need the intense level of Supported Employment Services. Long Term Vocation Supports provides periodic supports to the individual who, because of medical or behavioral needs, may require supports regarding the social or environmental issues that are a part of successful employment.

Documentation will be maintained in the file of each provider agency specifying that this service is not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) for this participant. This service is inclusive of transportation to and from the participant’s primary residence, the Long Term Vocational Supports setting and/or the community. Travel time is not actual service time and therefore actual billing for the service begins after the person reaches the site; the travel time is addressed through the rate established for the service definition.

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

FFP can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for training that are not directly related to a participant’s supported employment program.
- This service is not available at the same time of day as Day Supports, Home and Community Supports, Respite or one of the State Plan Medicaid services that works directly with the participant.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Long Term Vocation Support Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Long Term Vocational Supports

Provider Category:

Agency

Provider Type:

Long Term Vocation Support Provider

Provider Qualifications

License (*specify*):

--

Certificate (*specify*):

--

Other Standard (*specify*):

Provider must be endorsed by the LME as a provider of Long Term Vocational Supports

Staff Qualifications:

- Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200
- Staff must have a high school diploma or GED
- Staff must meet participant specific competencies as identified by the participant’s person-centered planning team and documented in the Person Centered Plan.
- Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training.
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, have a North Carolina or other valid drivers license a safe driving record and an acceptable level of automobile liability insurance.

Long Term Vocational Support Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
- Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial endorsement and re-endorsement at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

PERS (Personal Emergency Response System)

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

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

Service Definition (Scope):

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Provider Qualifications.

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

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Alert Response Centers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: PERS (Personal Emergency Response System)

Provider Category:

Agency

Provider Type:

Alert Response Centers

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Response Centers must be staffed by trained individuals, 24 hours/day, 365 days/year.

Meets applicable state and local requirements and regulations for type of device that the vendor is providing.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

At initial use and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Consultative Services

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

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

Service Definition (Scope):

Specialized Consultative Services provides expertise, training, and technical assistance in a specialty area (therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities who have long term habilitative treatment needs. Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency and increase the effectiveness of the specialized therapy. This service is also utilized to cover the cost of specialists identified as an integral part of the treatment 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 need for Specialized Consultative Services must be clearly reflected on the individual's person centered plan.

The activities below are covered under Specialized Consultative Services. These Activities take place with and without the person being present. These activities will be observed on at least a quarterly basis:

- Observing the individual prior to the development/revision of the person centered plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.
- Constructing a written person centered plan to clearly delineate the interventions and activities to be carried out by family members, caregivers, and program staff. The person centered plan details strategies, responsibilities, and expected outcomes.
- Training relevant persons to implement the specific interventions/supports/techniques delineated in the person centered plan and to observe the person, to record data, and to monitor implementation of therapeutic interventions/support strategies.
- Reviewing documentation and evaluating the activities conducted by the family members, caregivers, or program staff as delineated in the person centered plan with revision of that Plan as needed to assure continued relevance and progress toward achievement of outcomes.
- Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the person's Person centered plan on the specific interventions/activities, delineated in the Person centered plan, outcomes expected and review procedures.

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

- This service may not duplicate services provided to family members through Behavior Consultant, Individual/Caregiver Support Training and Education; and
- The total cost reimbursable under the waiver will not exceed \$1500 per person per waiver year

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Consultative Services
Agency	State Entity

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Consultative Services

Provider Category:

Agency

Provider Type:

Specialized Consultative Services

Provider Qualifications

License (specify):

Staff must meet the licensure certification requirement for the professional field in which they are consulting

Certificate (specify):

Other Standard (specify):

Staff Qualifications:

- Staff must meet the licensure certification requirement for the professional field in which they are consulting
- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
- Must have a criminal record check
- A healthcare registry check as required in accordance with 10A NCAC 27G.0200
- If providing transportation, a safe driving record and an acceptable level of automobile liability insurance have a North Carolina or other valid driver's license.

FFP can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
 - Payments that are passed through to users of supported employment programs; or
 - Payments for training that are not directly related to a participant's supported employment program.
 - This service is not available at the same time of day as Day Supports, Home and Community Supports, Respite or one of the State Plan Medicaid services that works directly with the participant.
- Specialized Consultative Services must be delivered by practitioners employed by mental health, developmental disabilities or substance abuse provider organizations that:
- Meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
 - Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS); and
 - Fulfill the requirements of 10A NCAC 27G

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of waiver

implementation or enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

The provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid’s approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial Endorsement and re-endorsement at every three years there after.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Consultative Services

Provider Category:

Agency

Provider Type:

State Entity

Provider Qualifications

License (specify):

Staff must meet the licensure certification requirement for the professional field in which they are consulting

Certificate (specify):

Other Standard (specify):

122C as appropriate

Operates under DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

LME

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Equipment and Supplies

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

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

Service Definition (Scope):

Specialized Equipment and Supplies include devices, controls, or appliances specified in the participant’s Person Centered Plan that enables the participant to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. Items under this service shall be directly attributable to the participant’s ability to avoid being institutionalized and shall exclude those items which are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. . There must be clear justification and documentation outlined within the Person Centered Plan for Specialized Equipment and Supplies.

The service includes the following categories of items:

Category 1: Adaptive Positioning Devices – standers, trays and attachments, prone boards and attachments, positioning chairs and sitters, multi-function physiosystem, bolster rolls and wedges, motor activity shapes, therapeutic balls, visualizer ball, physio- roll, therapy mats when used in conjunction with adaptive positioning devices and adaptive carseats.

Category 2: Mobility Aids - Specialized adaptive tricycles to improve the participant’s gross motor skills.

Category 3: Aids for Daily Living – adaptive eating utensils (cups/mugs; spoons, forks, knives, universal gripping aid for utensils, adjustable universal utensil cuff, utensil holder, non-skid inner lip plate, sloping, deep plates, scooper, plate guards, non-skid pads for plate/bowl, wheelchair cup holders); adaptive eating equipment; adaptive, assistive devices/aids including adaptive switches and attachments; mobile and/or adjustable tables and trays for chairs, wheelchairs, and beds; adaptive toothbrushes; universal holder accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral supports; adaptive toileting chairs and bath chairs and accessories not on the State DME list: adaptive hygiene/dressing aids, adaptive clothing, non-disposable clothing protectors; reusable incontinence garments with disposable liners for participants age two and above; dietary scales, food/fluid thickeners for dysphasia treatment; nutritional supplements that are taken by mouth such as those supplements covered by Medicaid for Home Infusion Therapy/Tube feedings; bed rails, assistive listening devices for participants with hearing and vision loss (TDD, large visual display devices, Braille screen communicators FM systems, volume control large print telephones, teletouch systems); medication dispensing

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

Specialized Equipment and Supplies may not be purchased through the waiver specifically for use in the school setting.

Specialized Equipment and Supplies will be a covered waiver expense only when not coverable under the Medicaid Durable Equipment Guidelines nor available for a child under the age of 21 as an EPSDT item. EPSDT coverage for children under the age of 21 applies to Durable Medical Equipment items outside of this code

Adaptative carseats for children shall be evaluated using prior criteria set by CSHS.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Businesses
Agency	Specialized Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initial use and then annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Specialized Vendor

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

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

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

Service Definition (Scope):

Transportation is a service offered to enable individuals served through the waiver to gain access to waiver and other community services, activities and resources, specified by the Person centered plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's person centered plan.

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

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

This service is limited to \$2000.00 per waiver year.

Additional Medicaid payment will not be made to provider agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid to the provider.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Provider (Self Direction Only)
Individual	Commercial/Retail Businesses (self direction only)
Individual	Specialized Vendor (Self Direction only)
Agency	Commercial/Retail Businesses
Agency	Specialized Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Independent Provider (Self Direction Only)

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing. Has current driving license, and a good driving history. Has appropriate insurance for vehicle use.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Commercial/Retail Businesses (self direction only)

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of transportation service that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management

Frequency of Verification:

Initially and Annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Specialized Vendor (Self Direction only)

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for Transportation service that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of transportation service that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Specialized Vendor

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for Transportation service that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and Annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Adaptation

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

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

Service Definition (Scope):

Vehicle Adaptations are provided only if the cost effectiveness of vehicle adaptations, relative to alternative transportation services is established in the person-centered Person centered plan. Vehicle adaptations are devices, controls, or services that enable individuals to increase their independence and/or physical safety. The repair, maintenance, installation, and training in the care and use of these items are included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the adaptive equipment manufacturer's authorized dealer according to manufacturer's installation instructions, and National Mobility Equipment Dealers' Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to Vocational Rehabilitation Services to acquire vehicle adaptation consultation services. The following types of adaptations to the vehicles are allowed:

- Door handle replacements.
- Door modifications.
- Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance.
- Lifting devices.
- Devices for securing wheelchairs or scooters.
- Devices for transporting wheelchairs or scooters.
- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel.
- Seating modifications.
- Safety/security modifications, including power-operated door openers.
- Handrails and grab bars.
- Installation of wheelchair flooring to insure wheelchair securement.
- Lowering of the floor of the vehicle.

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

Alterations to vehicles are limited to vehicles owned by the individual, or the individual's family. Excluded are vehicles owned by staff of licensed facilities, licensed and non-licensed Alternative Family Living homes and foster homes, including guardians in those settings.

The adaptations do not include the purchase price of the vehicle itself. All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications.

All equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to insure the most efficient use of Medicaid funds.

All Vehicle Adaptations must meet applicable standards and safety codes.

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

The cost of Vehicle Adaptations shall not exceed \$15,000 over the duration of the waiver (three years).

Alterations to vehicles are limited to vehicles owned by the individual, or the individual's family. Excluded are vehicles owned by staff of licensed facilities, licensed and non-licensed Alternative Family Living homes and foster homes, including guardians in those settings.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
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Agency	Commercial/Retail Businesses
Agency	Specialized Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Adaptation

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Adaptation

Provider Category:

Agency

Provider Type:

Specialized Vendor

Provider Qualifications

License (specify):

Applicable state/local business license

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing

Verification of Provider Qualifications

Entity Responsible for Verification:

Local Management Entity

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (select one):
- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
 - Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:
 - As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.
 - As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
 - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
 - As an administrative activity.** Complete item C-1-c.
- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case Management Services will be provided by Targeted Case Management Provider Agencies. These agencies must be enrolled with the Division of Medical Assistance. Case Management Agencies are monitored by the Local Management Entity. Case Management Agencies can not provide other direct services to individuals for whom they provide Case Management

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

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

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

Criminal background checks must be conducted on all prospective employees MH/DD/SAS provider agencies who may have direct access to individuals served. This includes direct care positions, administrative positions, and other support positions that have contact with individuals served. When prospective employees have lived in North Carolina for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

Criminal Record checks must be obtained for any job applicant under serious consideration. Criminal background checks must be performed in advance of payment to the employee for the performance of services. The results of the criminal record check do not mandate that the prospective employee is not hired but must be taking in consideration in the hiring decision.

The provider's responsibility to conduct criminal record checks on all employees who have direct access to participants is monitored by the LME during the endorsement procedure and during routine provider monitoring. The Accountability Team of DMHDDSAS also monitors this process during provider audits.

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Department of Health and Human Services, Division of Health Service Regulation, maintains the Health Care Personnel Registry and the Nurse Aide Registry according to North Carolina General Statute 131E-255. Nurse Aide Registry is specifically for nurse aids working in nursing facilities. The Health Care Personnel Registry's information is specific to Health Care Facilities. A Health Care Facility is defined in North Carolina General Statute 131E-255 defines a Health Care Facility as licensed facilities and unlicensed community based providers of service to individuals with developmental disabilities.

Providers of CAP-MR/DD Waiver services are required to conduct Abuse Registry screenings of perspective employees prior to that employee providing services as stated in North Carolina General Statute 131E-255 and 10A NCAC 27G.0202.

Information from both the Nurse Aide Registry and the Health Care Personnel Registry is available to the general public and all health care providers via the Internet through a 24-hour telephone voice response system.

The provider's responsibility to conduct abuse registry checks on all employees who have direct access to participants is monitored by the LME during the endorsement procedure and during routine provider monitoring. The Accountability Team of DMHDDSAS also monitors this process during provider audits.

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

Parents, step parents, or adoptive parents may not provide services to their minor children.

Parents, step parents, or adoptive parents of adult children or any other family member residing with the participant may not provide services to the participant.

A spouse of a waiver participant may not provide services to the participant.

The LME will review all Person Centered Plans to ensure the appropriateness of the request for the guardian of the person to provide paid care and to address possible conflict of interest issues. Guardian of the Estate or General Guardian may not provide services to the participant for whom they are guardian.

When family members or guardians are paid care providers the PCP must outline measures that will assure the individual's choice and control over their daily lives and assure community integration. Case Managers will monitor for compliance with these measures as well as evidence of social isolation and lack of individual involvement in their life choices.

When family members are the paid care provider, there must be a clearly defined back-up plan as required by the PCP that specifies who will provide the care if the family member is unable to do so.

Any relative or Guardian of the Person who is providing services must meet required provider qualifications based on the service provided.

The relative or Guardian of the Person is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.

The relative or Guardian of the Person must meet required provider qualifications based on the service provided. Parents and/or family members and/or Guardians of the Person who wish to provide services to the participant for whom they are guardian, must be hired by an endorsed provider agency and must meet the same requirement of other staff members.

- **Other policy.**

Specify:

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

Provider organizations that wish to provide and seek reimbursement for CAP MR-DD services must be endorsed by the LME and directly enrolled by DMA. The LME(s) are required to complete the Provider Endorsement process per request by providers seeking to become directly enrolled Medicaid providers. Provider Endorsement is a verification and quality assurance process using statewide criteria and procedures. Provider Endorsement is a prerequisite for direct enrollment with the DMA and consists of two parts: business verification and site/service approval. An endorsed provider MUST be directly enrolled by DMA prior to delivering and billing covered Medicaid services.

A provider organization seeking enrollment in the North Carolina Medicaid program as an In-State or Border Provider of MH/DD/SA services to consumers from North Carolina, whose physical location is within the limits established by the Division of Medical

Assistance shall meet the requirements for endorsement. In this case a provider who has a business office outside of N.C., the business verification will be conducted by the LME Agency receiving the initial application for endorsement.

Endorsement and Medicaid enrollment for CAP-MR/DD Waiver services is service specific and shall be honored by all LMEs. Should a provider that is endorsed by one LME seek to provide services to participants of other LMEs, those other LMEs shall verify that the provider’s endorsement is current and valid before entry into the Standard Agreement and making referrals to the provider. In order to ensure providers continue to meet established quality standards LME(s) conduct re-endorsement of providers three years after the initial endorsement. This process includes verification of the National Accreditation status of the provider and a letter of attestation that includes the current business information (name, business status, and address), and any dissolutions, revocations, or revenue suspensions that have occurred over the past 3 years. The LME shall retain the right to conduct an onsite review based on the information contained in the letter of attestation. If the information submitted meets endorsement requirements the LME shall renew the Provider endorsement for three more years. If at any time the provider organization’s National Accreditation status lapses or is withdrawn the provider organization must notify the LME.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Performance Measure:a.i.a.1 Proportion of licensed residential and day services that received a type “A” violation within the past year. N=All current licensed residential and day services sites with type “A” violations within the past year D=All current licensed sites

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHSR Annual Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: Division of Health Service Regulation		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.a.2 Proportion of providers whose endorsement has been withdraw.
N=All endorsed providers whose endorsement has been withdraw within the past year. D=All
endorsed providers within the past year

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS data base

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other

		Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.a.3 Proportion of audited providers wherein direct support staff had criminal background checks before providing services. N= Total number of audited providers whose direct support staff had criminal background checks before providing services. D=Total providers audited during the year

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual Accountability Audit

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Provider agencies
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.a.4 Number of providers wherein direct support staff had Health Care Personnel Registry checks before providing services. N= Total providers whose direct support staff had timely criminal background and Health Care Personnel Registry checks D=Total providers audited during the year

Data Source (Select one):

Other

If 'Other' is selected, specify:
Annual Accountability Audit

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = .05%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Provider agencies
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

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

Performance Measure:

Performance Measure:a.i.b.1 Proportion of non-licensed Alternative Family Living (AFL) providers that are in compliance with DMH/DD/SAS waiver specific standards N= All monitored non-licensed AFL sites that have 100% compliance with DHHS waivers specific standards D= All non-licensed AFL sites monitored during the year

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.b.2 Proportion of non-licensed providers of waiver services that are monitored by the LME at least one time per year. N=All All non-licensed/non-certified providers of waiver services who must be monitored at least annually. D=All non-licensed/non-certified providers of waiver services

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Provider Agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>

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

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

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

Performance Measure:

Performance Measure:a.i.c.1 Proportion of reviewed providers wherein staff have successfully completed training on alternative techniques to restrictive interventions. N= All reviewed providers whose staff have successfully completed training on alternative techniques to restrictive interventions. D = Total number of reviewed providers.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100px; height: 20px;" type="text"/>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: Break out by LMEs, provider agencies and provider agencies that have not implemented this training
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):
 Provider performance monitoring
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: provider agencies that have not implemented this training
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

Performance Measure:

Performance Measure:a.i.c.2 Proportion of reviewed providers wherein all staff have successfully completed all required training (do not include exceptions to restricted interventions training).
N= All reviewed providers wherein staff have successfully completed all required training D = Total number of reviewed providers.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LMEs and provider agencies
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> Other Specify: _____	

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LMEs and provider agencies

<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Performance Measure:a.i.c.3 Proportion of reviewed case management agencies wherein case managers have successfully completed all required case management training. N= All reviewed case management agencies wherein case managers have successfully completed all required case management training. D = Total number of reviewed case management agencies

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LMEs and provider agencies and provider agencies that have not implemented this training
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LMEs and provider agencies that have not implemented this training
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to

discover/identify problems/issues within the waiver program, including frequency and parties responsible.

a.i.a.1 -4. The LME initially endorses all providers prior to service provision, but cannot endorse if the provider is found to be out of compliance with any licensing or certification standard. The Division of Health Services Regulations (DHSR) licenses the provider agency, if it meets all licensing requirements. The LME and DMH/DD/SAS Accountability Team monitor the providers on a scheduled basis. Their monitoring includes reviewing the provider's documentation and observing service provision, both of which may indicate whether licensing and/or certification requirements have/are being met. DHSR monitors each licensed provider annually to see if all licensing requirements are being met. Data will be generated by the all reviewers based on findings and LME. The annual reports will be written by the reviewing agency. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

a.i..b.1-2.

For non-licensed, non-certified providers, the LME reviews the provider's qualification documents and endorses the provider if all qualifications are met. The LME monitors the provider on an ongoing basis, as does the DMH/DD/SAS Accountability Team. DMH/DD/SAS reviews all MFP participants' PCPs as well as those plans over \$100,000 and the UR vendor reviews all other PCPs. These reviews determine whether plans comport with the state's policies and procedures, including any required assessments, timelines, crisis plans, risk assessments, etc. DMA also conducts monthly reviews of a sample of PCPs. In addition, the DMH/DD/SAS Accountability Team reviews PCPs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed as part of the review of case management agencies.

Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

a.i.c 1-3.

The LME as well as DMA and DMH/DD/SAS (Accountability Team) are responsible for monitoring the providers to ensure the provider has documentation to verify all staff training has been conducted in accordance with state requirements and the approved CAP-MR/DD waiver. This includes, but is not limited to reviewing First Aid, CPR and medication administration training, alternatives to restrictive interventions and person centered thinking as well as training specific to caring for individual participants. Provider monitoring includes the case management agencies' documentation to prove all case managers have completed all required case management training. These monitoring activities are vital for the success and safety of participants. DMA and DMH/DD/SASE conduct the Annual Accountability Audit together. Data will be generated by the reviewers based on findings and grouped by the provider agencies, agencies that have not implemented the specific training and LMEs. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team and the Accountability Team.

b. Methods for Remediation/Fixing Individual Problems

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

a.i.a.1 -4.

If the LME or DMH/DD/SAS Accountability Team finds an endorsed provider out of compliance with any certification standard, they may require a Plan of Correction (unless the compliance issue may or is endangering participants, in which case the endorsement could be immediately revoked) . The same is true if DHSR finds a licensing issue. The provider has 15 days to submit the plan of correction.

DHSR also conducts an investigation of a licensed provider against whom a complaint has been lodged. Results of the investigation will be shared with DMH/DD/SAS and the person who submitted the complaint. When DHSR finds a licensing compliance issue, they may require a plan of correction, fine the provider, or revoke the provider's license. If a provider's license is revoked, their endorsement to provide services is immediately revoked as well.

After an agency submits a Plan of Correction, the LME or Accountability Team will conduct a follow up review to determine if the provider has corrected the issues. If not, the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

a.i.b.1-2

If the LME or Accountability Team finds the provider out of compliance, they require a Plan of Correction. The LME or Accountability Team will then conduct a targeted monitoring review to determine if the provider has corrected the issues. If not the LME or Accountability Team may require another Plan of Correction. The LME may withdraw the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

a.i.c. 1-3

If the LME or Accountability Team finds the provider out of compliance they may require a Plan of Correction. The Plan of Correction should indicate that all staff who have not completed all required training will not provide services to participants

until they have completed the required training. The LME or Accountability Team will conduct a follow up review to determine if the provider has corrected the issues. If the issues are still not corrected the LME or Accountability Team may require another Plan of Correction. The LME may withdraw the provider's endorsement. The Accountability Team can also require the provider to reimburse DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action

ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Timelines**

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

- No
- Yes

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

A provider monitoring tool is currently under development and is expected to be implemented July 1, 2009. This tool will be used by the LME to evaluate how well the providers are meeting state standards and requirements. If problems are identified, the LME will provide, as needed, technical assistance or training, require a plan of correction as needed, and conduct additional monitoring as needed. Uncorrected monitoring findings could lead to loss of endorsement by the provider.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

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

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

Participants who are self directing their services will receive an individual budget. The budget will be determined by participant needs as described in the Person Centered Plan and supported by NCSNAP, MR2, and other assessments such as the Psychological assessment or the Supports Intensity Scale as appropriate. If a situation occurs affecting the health and safety of the participant, the Person Centered Plan would need to be reviewed and plans made. The budget may be revised up to \$17,500, the upper limit of the Supports Waiver. If this amount does not assure the health and safety need of the participant, state funds will be accessed if available and application may be made to the Comprehensive Waiver. The Comprehensive Waiver has reserved slots for individuals who need to transfer to the Comprehensive Waiver from the Supports Waiver.

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

Participant services will be determined by participant needs as described in the Person Centered Plan and supported by NCSNAP, MR2, and other assessments such as the Psychological assessment or the Supports Intensity Scale as appropriate. Participants may receive up to \$17,500 of approved services in this waiver. If this amount does not assure the health and safety need of the participant, state funds will be accessed if available and application may be made to the Comprehensive Waiver. The Comprehensive Waiver has reserved slots for individuals who need to transfer to the Comprehensive Waiver from the Supports Waiver.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Plan

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

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

Specify qualifications:

Case Managers are professionals whose education, skills, abilities, and experience enable them to perform the activities that comprise Medicaid case management services. Qualified case managers shall meet the qualifications in (i) and (ii).

(i) Be a qualified Developmental Disabilities Professional (QDDP) as defined below;

An individual holding at least a baccalaureate degree in a discipline related to developmental disabilities and at least two fulltime years of supervised experience by a QDDP in working with the individuals with mentally retardation or who are otherwise developmentally disabled or hold a baccalaureate degree in a field other than one related to developmental disabilities and have three fulltime years of supervised QDDP experience in working with individuals with mentally retardation or who are otherwise developmentally disabled; and

(ii) Staff must successfully complete First Aid, CPR, and other trainings required by the DMH/DD/SA, and specific participant related competencies, along with any required refresher courses. Staff must have a criminal background check. Staff must have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance, and NC Health Care Registry.

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each participant chooses a case manager responsible for facilitating the person centered planning process. The process emphasizes a strength based approach, collaborative problem-solving and decision-making with the participant and those persons that are most important in his/her life. The participant guides the plan and chooses participants to assist. Family members and friends are frequent contributors and professional service providers are included as deemed relevant by the participant in consultation with the targeted case manager.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service

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

A written Person Centered Plan will be developed with each participant utilizing a person-centered planning process that reflects the needs and preferences of the participant.

Person Centered Planning is a means for people with disabilities to exercise choice and responsibility in the development and implementation of their support plan. A good person centered plan generates actions, positive steps that the person can take towards realizing a better and more complete life. Good plans also ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided. Plans draw upon diverse resources, mixing paid; natural; and other non-paid supports to best meet the goals set. The Person Centered Plan is expected to address how the provider will ensure back up staff are available (if the staff regularly assigned to provide services are unavailable). The back up staff must be trained to meet the specific needs of the participant, as detailed in the Person Centered Plan, including health, mobility, communication, risks behavioral issues, and skill training. All participants are informed of and provided information related to back-up staff at the time of identification of provider and during the PCP process.

Person centered planning is defined as a process, directed by the planning team. The person centered planning process are developed for participants with long-term services and supports, intended to identify the strengths; capacities; preferences, needs and desired outcomes of the participant. The process includes people, freely chosen by the family of the minor or adult participant who are able to serve as important contributors. The person-centered planning process enables and assists the participant to identify and access a personalized mix of non-paid and paid services that will assist him/her to achieve personally defined outcomes in the most inclusive community setting. The participant identifies planning goals to achieve these personal outcomes in collaboration with those that the participant has identified, including medical and professional staff. The identified personally defined outcomes and training, supports, therapies, treatments, and other services the participant is to receive to achieve those outcomes become a part of the person centered plan. The person centered plan is updated annually, however if the participant's provider changes or needs change and requires services to be added, increased, decreased or terminated a revision to the plan shall be completed and submitted to the state wide utilization vendor for approval. The case manager is responsible to make monthly face-to-face visit with participants in a variety of settings in which non-paid and paid services are being rendered with the participant to inquire about any concern or problem with service provision and/or health and safety and to insure that services are furnished in accordance with the PCP. The case manager reassess each participant's needs at least annually and develops an updated person centered plan (Continued Need Review-CNR), based on that reassessment. The case manager will follow-up and resolve any issues related to the participant's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME and provider agency by the case manager to resolve these issues. The case manager will provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. In the event the service plan (PCP) developed results in denial of services, by the statewide utilization vendor, the case manager will inform the participant of the right to request a Fair Hearing. The case manager will assist the participant and the family through the Fair Hearing process. The case manager will inform the participants of grievance and complaint resolution processes. This process should take place on an annual basis during the Continued Need Review process which is the annual person centered planning process.

Also as part of the annual review, the case manager, in consultation with the participant and the team, will identify the Most Integrated Setting appropriate for the individual for supports and services (i.e residential, day) to be provided. If the Most Integrated Setting is not available, the case manager will document in the individual's file the supports and services needed to achieve the Most Integrated Setting, as well as the obstacles and barriers in achieving the Most Integrated Setting.

The following description includes examples of assessment tools that are utilized to develop and assist with the person centered planning process. The results from the assessments should be considered and incorporated within the person centered plan as appropriate. It should be noted that other assessment tools can be used beyond these listed that reflect the participants needs, preferences and for health and safety measures:

- A comprehensive assessment is a functional face-to-face evaluation that supports the person centered planning process for individuals with developmental disabilities. In many cases, persons with a developmental disability have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach to addressing their needs. Since developmental disabilities are life long conditions, the focus of the comprehensive clinical assessment is on identifying the person's current functioning status and identifying needed supports to help the person achieve and maintain maximum independence. Such an approach often requires a variety of clinical assessments (e.g., intellectual assessment, psychiatric assessment, physical evaluation, educational/vocational assessment, PT/OT evaluation). It should also be noted that the assessment is not a one-time event. A person with a developmental disability may require periodic assessments to determine their ongoing needs. This written report also includes recommendations for services, supports, and/or treatment which are integrated into the person centered plan.

- The NC-SNAP (North Carolina- Service Needs Assessment Profile). The NC-SNAP is an assessment tool that measures an

individual's need for developmental disabilities supports and services. An individual's case manager will have primary responsibility for the administration of the NC-SNAP. Additionally, the NC-SNAP can be used as an initial step in the development of a person-centered support plan. It identifies needs, which can be met through a variety of services. As these needs are identified supports and services are implemented in the person centered plan.. All participants who are currently served under the CAP MR/DD waiver have an NC-SNAP administered annually or whenever there is a significant change in the participant's need profile.

- The Supports Intensity Scale (SIS) is an optional assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports an individual needs to live as independently as possible within their community. A major strength of the SIS is that it identifies supports that are needed to help an individual be successful in a variety of life domains. As such, during the person centered planning meeting, as needs are identified, corresponding supports should also be identified to assist the participant in meeting those needs.

These assessment tools described are not to be used independently but in collaboration to identify the needs; wants and preferences; supports; intensity; strengths; and deficits of the participant during the person centered planning process.

Services and supports for participants should be planned as well as implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. The following items are included in the system:

- Comprehensive information regarding the participant or family's preferences and personal goals, needs and abilities, health status as well as other available supports is gathered with the participant or family and used in the development of a person centered plan. Information and support is available to assist participant and families to make informed choices regarding service options as well as providers.
- Information and support is available to assist participants to freely choose among qualified providers.
- Each participant's PCP comprehensively addresses his/her identified need for supports, health care and other services in accordance with expressed personal preferences and goals.
- Participants and families have continuous access to assistance as needed to obtain and coordinate services and quickly address issues encountered in community living.
- All services and supports are provided in accordance with the person centered plan.
- Regular, systematic and objective methods, including participant or family feedback, are used to monitor the participant's well being, health status, and the effectiveness of supports and services in enabling the participant to achieve personal goals.
- Significant changes in the participant or family's circumstances promptly trigger consideration of modifications to the person centered plan.

The Person Centered Plan will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who will furnish each service or support.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As a preliminary step, the MR2 assessment form which documents ICF-MR level of care, along with the NC-Service Needs Assessment Profile (NC-SNAP), will be used to identify potential risks to the participant. A Crisis Prevention Plan is incorporated within the PCP. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive).

A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably. The Crisis Prevention Plan should include what positive skills the participant has which can be elicited and increased at times of crisis. How to implement redirection of energies towards exercising these skills that can prevent crisis escalation. How to implement positive behavioral supports that may be relied upon as a crisis response. The Crisis Prevention Plan is an active and living document that is to be used in the event of a crisis. After crisis, the participant and staff should meet to discuss how well the plan worked and make changes as indicated.

Other assessment tools will be utilized to identify risk, these tools include but no limited to the Risk Assessment tool and the Support Intensity Scale (SIS). The Risk Assessment tool identifies potential risk, such as but not limited to situational; environmental; behavioral; medical; and financial. If a risk is identified and the planning team concurs, the risk identified will be documented within the Crisis Prevention Plan of the Person Centered Plan. Intervention strategies will be developed to alleviate or prevent these risks. The Supports Intensity Scale is an assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports a participant needs to live as independently as

possible within their community. A major strength of the SIS is that it identifies supports that are needed to help an participant be successful in a variety of life domains. As such, during the person centered planning meeting, as needs are identified, corresponding supports should also be identified to assist the consumer in meeting those needs. The Person Centered Plan will identify and document strategies to address risks identified in the Risk Assessment Tool and the SIS. The Risk Assessment Tool and the SIS can be used independently or in collaboration to identify potential risk to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Case managers will work with participant to identify potential sources of services and support; paid and non paid natural supports within their catchment areas. In addition, participants who choose to self-direct their services may have the aid of a community resource advisor who will assist them in identifying services and supports and providers of those supports and services. Also, the LME will ensure that participants will have freedom of choice of qualified providers

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The process for review and approval/authorization of participant Person Centered Plans is a primary function of the DHHS contracted state wide utilization vendor.

Annually the Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of directly enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, Person Centered Plans, service documentation, and billing protocol.

The Behavioral Health Unit of DMA conducts quality assurance reviews monthly that include a review of the Person Centered Plan for participants in the waiver. Each month DMA selects a random sample of waiver cases that were active on the last day of the review month. Reviews occur either on site or the records are sent to DMA for a desktop review. The reviewer looks for a current MR2, documentation that the participant is at risk of institutionalization or was de-institutionalized, where the participant resides while on the program, and a current, approved Person Centered Plan to insure that services are appropriate to the needs of the participant. The Person Centered Plan is further reviewed to insure that services and supports provide for the participant's health, safety and well being and that services were provided according to the approved Person Centered Plan during the review month.

These reviews are conducted to assure that the following quality outcomes are achieved:

- Services and supports provide for the participant's health, safety and welfare.
- Participants approved for participation in the program meet eligibility criteria;
- Participants were given a choice between waiver participation and institutional care;
- Services are cost-effective according to program criteria;
- Services are appropriate to the participant's needs;
- Services were provided according to the approved Person Centered Plan during the review month; and
- Services are cost-effective according to program criteria;

The review is also conducted to assure the availability of information and other services in accordance with the participant's expressed personal preferences and goals, that services are appropriate to the participant's needs, services are provided in accordance with the Person Centered Plan and the services and supports lead to positive outcomes for the participant.

Other quality outcomes addressed by the review include support to help participants make informed selections among service option and availability of information and support to assist the participant to freely choose among qualified providers. Additional outcomes assure that services are cost-effective according to program criteria, and there is evidence that contingency plans have been established for emergencies and to ensure emergency backup when formal providers are not available.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The following entities are responsible for monitoring of service plan(PCP) implementation and participant health and welfare:
Participants will:

- Contact their case managers and community resource advisor (for those participating in self direction) if they have concerns about their services or supports
- Access grievance and complaint processes and appeals, with assistance from their case managers, if needed, based on written materials provided by the DHHS contracted state wide utilization vendor.

The Case Manager will:

- Advocate for the participant.
- Coordinate, locate and monitor services and supports
- Make the expected monthly face-to-face visit with participants in a variety of settings in which non-paid and paid services being rendered with the participant to inquire about any concern or problem with service provision and/or health and safety and to insure that services are furnished in accordance with the service plan.
- Reassess each participant's needs at least annually and develop an updated Person Centered Plan(Continued Need Review-CNR) based on that reassessment.
- Follow-up and resolve any issues related to the participant's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME and provider agency.
- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. During the annual review of the person centered plan process the Case Manager informs the participant of their choice to continue to participate in Home and Community Based Services or to choose community ICR-MR services. This allows participant's choice as indicated by the participant and/or guardian's signature on the Freedom of Choice Statement. Participants will also be notified of grievance and complaint resolution processes. This process should take place on an annual basis during the Continued Need Review

process which is the annually person centered planning process.

- Identify on an annual basis the Most Integrated Setting appropriate for the individual for the provision of supports and services
- Monitor quality assurance measures as specified in this Supports Waiver.

The Community Resource Advisor (only for those participating in Self-Direction) will:

- Advocate for the participant.
- Assist with defining goals, needs and preferences, identifying and accessing services, supports and resources that are to be documented in the person centered plan
- Development of risks management agreements and assists participating to make informed decisions about what will work best for them and about what services and supports are consistent with their needs and reflect their individual circumstances and document this information within the person centered plan.
- Serving as the agent of the family or participant, they are available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services in the person centered plan.
- Assist the participant in design of an individual budget.

The Financial Management (only for those participating in Self-Direction) will:

- Assist the participant or family to manage and distribute funds contained in the Individual Budget including, but not limited to, the facilitation of the employment of service workers and purchase of services by the individual or family, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports. The FMS is responsible for criminal background checks.

Local Management Entities will:

- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Participants will also be notified of grievance and complaint resolution processes.
- Resolve issues related to any participant's health, safety or service delivery.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by Department of Health and Human Services (DHHS) rules
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS Rules
- Ensure that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an participant may be abused, neglected or exploited and in need of protective services
- Complete and submit Quarterly Reports to DMH/DD/SAS, and the local Client Rights Committee to include the following incidents: Level II and III incidents which include aggregate numbers of types of incidents, local trends identified in the LME's analysis and actions they have taken to prevent future incidents
- Address complaints concerning the provision of public services
- Submit a report of monthly local monitoring activities to the Division of MH/DD/SAS identifying provider monitoring issues requiring correction and an explanation of uncorrected issues.

The DHHS will complete:

- Monitoring of waiver providers includes yearly audits of paid claims to waiver providers. The sample used in determining the providers to be audited is chosen in a manner to offer statistical assurance of the overall performance of all waiver providers. In addition, providers with previous records of low performance are routinely included in the sample. When there are out-of-compliance findings for any of these audits, Plans of Correction are required, and the State follows these plans with reviews to assure correction of system issues which contribute to out of compliance findings. Should corrections not be made, the option of suspension or revocation of a provider's privileges to bill is available.
- Investigations of incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services.
- Review of Quarterly Reports of monitoring and incidents submitted by the LME.
- Tracking and investigate of deaths of participants.

b. Monitoring Safeguards. *Select one:*

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

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

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Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Proportion of Person Centered Plans (PCP) that reflect assessed needs and preferences. N =Total number of reviewed PCPs that reflect assessed needs and preferences D =Total number of reviewed PCPs

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Monitoring data

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LME,case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Monitoring

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LME, case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Accountability Audit database

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LME, case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS database

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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<i>that applies):</i>	<i>that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: LME, case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of families who are satisfied with the services and supports their family member (participant) currently receives. N= All respondents who answered always and almost always to this Core Indicators Adult/Family Survey D = Total number of respondents who answered Core Indicators Adult/Family Survey

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Adult/Family Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of surveyed participants who responded “yes” to “Do you know your case manager?”

N= All respondents who answered yes to this Core Indicators Consumer Survey
D = Total number of respondents who answered Core Indicators Consumer Survey

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of initial MFP Person Centered Plans (PCP) that contain a provider 24-hour backup plan in the Crisis Plan. N =Total number of reviewed PCPs that that contain Risk Assessments in the Crisis Plan. D =Total number of reviewed PCPs

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS database

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Proportion of PCPs that are completed in accordance with DMH/DD/SAS requirements. $N = \text{Total number of reviewed PCPs that meet DMH/DD/SAS requirements}$ $D = \text{Total number of PCPs reviewed}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by MFP, LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Proportion of PCPs indicating appropriate change in service related to documented change in participant's needs within the year. N=Total number of PCPs that were revised to address need changes D=Total number of PCPs reviewed with evidence of change of need

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Monitoring

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by MFP,LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider performance monitoring

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by MFP,LME and case management agency
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
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Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual accountability Audit database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by MFP,LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

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

Performance Measures

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

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

Performance Measure:

Proportion of PCP's billing reflecting the type, amount, duration and frequency of specified services are delivered as specified each month. N=Total number of reviewed PCPs reflecting the type, amount, duration and frequency of specified services are delivered as specified each month. D=Total number of reviewed PCPs

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Review

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: MFP, LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Monitoring database

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: MFP, LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual Accountability Audit database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: MFP, LME and case management agency
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

--	--

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

Performance Measures

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

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

Performance Measure:

Proportion of participants /guardians who have signed the initial PCP signature page indicating they were given choices of providers. N=Total number of participants who have indicated they were given choices of providers. D=Total number of initial PCPs

Data Source (Select one):

Other

If 'Other' is selected, specify:

UR vendor initial review

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: UR vendor	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by case management agency and LME
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of MFP participants /guardians who have signed the PCP signature page indicating they were given choices of providers. N=Total number of MFP participants who have indicated they were given choices of providers. D=Total number of PCPs of MFP participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Case management agency and LME
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: <input style="width: 95%;" type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 95%;" type="text"/>

Performance Measure:

Proportion of MFP participants/guardians who have signed the PCP signature page indicating they were given the choice of institutionalization or Waiver services. N=Total number of MFP participants who have indicated they were given the choice of institutionalization or Waiver services. D=Total number of PCPs of MFP participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMH/DD/SAS database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 80%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 95%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 95%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 95%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 95%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 95%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Other
Specify:

Performance Measure:

Proportion of participants/guardians who have signed the PCP signature page indicating they were given the choice of institutionalization or Waiver services. N=Total number of participants who have indicated they were given the choice of institutionalization or Waiver services.
D=Total number of PCPs of participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

UR vendor monthly review database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: UR Vendor	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Case Management agency and LME
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

QM = Quality Management Team

In order to ensure that all PCPs address the assessed needs and goals of individual participants, the state uses a variety of methods, including the utilization review of all PCPs/by the UR vendor and a review of a random sample of PCP by the DMA. DMH/DD/SAS reviews all plans for participants who are self directing. PCP development will be reviewed during the ongoing monitoring process, including determining whether assessments are conducted as required, strategies in the plan address assessed needs, services are being implemented and the case manager is monitoring the plan. Monthly reports will be written by the reviewing agencies.

National Core Indicator data will be collected annually on participant/guardian opinions regarding their satisfaction with the way the PCP meets the needs of the participant. These data, along with data generated by the reviewing agencies, will be aggregated, analyzed and reported by the DMH/DD/SAS QM Team.

The DMH/DD/SAS reviews participants' who are self directing their services. These reviews determine whether they comport with the state's policies and procedures including any required assessments, timelines, crisis plans, risk assessments, etc. The DMA also conducts monthly reviews of a sample of PCPs. For participants who are self directing DMH/DD/SAS staff will review each plan to determine that policies and procedures are honored. In addition, the DMH/DD/SAS Accountability Team reviews PCPs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed during regular monitoring of case management agencies.

Data will be generated by the reviewers based on findings. Monthly reports will be written by the reviewing agencies (DMA,DMH/DD/SAS). The annual aggregate data will be analyzed and reported by the DMH QM Team.

b. Methods for Remediation/Fixing Individual Problems

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

If the PCP of an MFP participant is found by the DMH/DD/SAS to be out of compliance, the reviewer will notify the case manager. The case manager has five (5) calendar days to submit the corrections to the DMH/DD/SAS. The DMH/DD/SAS tracks whether the plan is revised in an adequate fashion. DMH/DD/SAS will follow up with the case manager to ensure that changes have been made.

The DMH/DD/SAS will review aggregate data on PCP compliance to determine any systematic issues and trends.

If a state reviewer discovers a PCP out of compliance, a plan of correction will be required. The case manager has 5 days to submit the correction. The DMH/DD/SAS or DMA reviewer follows up to ensure the issue was resolved.

If the LME finds a PCP out of compliance during the provider review, the LME will require a plan of correction and will follow up to ensure that issue is rectified. If the problem persists, the LME can withdraw the provider's endorsement.

When the DMH/DD/SAS identifies a participant whose PCP has not been revised based on participant needs, staff will contact the LME who will in turn contact the participants' case manager and ask for a plan of correction. Further, if the DMH/DD/SAS Accountability Team, DMA, or LME provider monitoring uncovers individuals whose needs have changed without the appropriate plan revision, the LME will ask for a plan of correction and follow-up with the case manager.

If it is discovered that services are not being delivered in accordance with the PCP, the targeted case manager or LME addresses the issue(s) with the provider and works with the provider to resolve the issue. If the provider fails to resolve the issue adequately, the targeted case manager may address the issue with the participant and suggest a change of provider. The provider can be reported to DMA's Program Integrity unit for auditing if warranted. The LME can also withdraw the provider's endorsement.

If the UR vendor reviewer finds the signature(s) to be missing, the reviewer contacts the case manager to secure the required signatures. The DMH/DD/SAS reviewer may contact the UR vendor or the case manager directly and request the appropriate signatures be obtained. The case manager has 5 calendar days to submit the requested signatures.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing <input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix E: Participant Direction of Services

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

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

The intent of the self direction in the Supports waiver is two-fold: 1) to support participants who choose to live in their own or their family home, with a real alternative to out-of-home congregate settings through a flexible service array; and 2) to provide participants with the opportunity and the supports and services needed to self-direct their own services to the extent desired. This will be accomplished through the provision of a service array that provides both the opportunity to self-direct or to be provider directed. Under the self-directed option, participants will have the ability to choose/hire the support staff to provide their care; train, supervise and evaluate their support staff; negotiate pay rates; release the support staff when necessary; and engage in a working arrangement with a Financial Manager who will pay the participant's staff, and who will handle federal/state taxes and other payroll or benefits

related to employment of the support person. All waiver participants who choose to self direct will receive Community Resource Advisor services.

The services provided under the Supports Waiver will provide for participants to live in communities of their choice with the supports needed to ensure the health and safety of the participant. All initial, annual and revised Person Centered Plans for participants who self direct will be reviewed by DMH/DD/SAS.

Services which may be agency or participant-directed included within the waiver are:

- oPersonal Care
- oRespite Services
- oTransportation
- oParticipant/Natural Support Training and Education Services
- oHome and Community Support Services
- oIndividual Goods and Services

Agency directed services will include the following and these services are available to those who chose to self direct their services:

- Augmentative Communication
- Home Modifications
- Specialized Equipment and Supplies
- Personal Emergency Response System
- Vehicle Adaptations
- Adult Day Health
- Day Supports
- Long Term Vocational Support
- Specialized Consultative Services
- Crisis Respite
- Crisis Services
- Behavioral Consultation
- Supportive Employment
- Transportation
- Home and Community Supports
- Individual Goods and Services
- Participant/Natural Support Training and Education Services

Case Management services will be available under the NC State Plan (SPA) and Financial Management services and the Community Resource Advisor will be administrative costs and therefore not reflected as a service in the participant's individual budget.

Case managers are responsible for providing information to participants and families regarding self direction. Participants who state an interest in directing their services will be assessed to determine risks and support needs related to self direction. Participants may choose to include a non-paid representative to act on their behalf.

A participant, who has received waiver services in the past year, will have their individualized budget based upon the previous years cost summary of services. For a new participant in the waiver, their individualized budget will be based upon the support needs indicated in the Person Centered Plan.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

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

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Those participants who chose not to self direct their supports/services in the Supports waiver will utilize the provider directed model of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a) A comprehensive set of materials will be used to assist participants in learning about self directed services. Materials include an informational brochure, a guide for directing one's own services, and a power point presentation and a video of the delivery of the power point presentation on the DMH/DD/SAS website.

b) Primary responsibility for furnishing information will be vested with case manager. Participants and /or family members will be informed of all of the roles and responsibilities associated with a self directed model including but not limited to:

1. working with a Financial Management entity, and a Community Resource Advisor
2. managing an individual budget
3. legal and financial obligations as an employer of individual providers
4. hiring and supervising individual providers and staff.
5. potential benefits and risks to self direction

c) In addition, participants/legally responsible persons/ non paid representatives will be informed of the following by the Case Manager:

- 1) if they choose to participate in self directed model, they may change this decision and receive provider managed services for which they are eligible;
- 2) when they elect to participate in the self directed model they can choose a non-paid representative to assist with making decisions

and directing services and supports, or the legal representatives of the participant will assist with these functions

3)Financial Management entity will be the employer of record.

d)Case managers will inform participants and families of the option to direct services and supports during the assessment and person centered planning process.

e)under the self-directed option, participants will have the ability to choose/hire the support staff to provide their care; train, supervise and evaluate their support staff; negotiate pay rates; release the support staff when necessary; and engage in a working arrangement with a Financial Management entity that will pay the participant’s staff, in addition to other financial and accounting duties.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

The State does not provide for the direction of waiver services by a representative.

The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The Local Management Entity (LME), case manager, Community Resource Advisor and Financial Management entity must recognize a participant’s representative as a decision-maker for the participate and provide the representative with all the services, information, training, and support it would provide to a participant.

The representative must be informed of the rights and responsibilities of a representative of a participant of self directed services. The representative must sign an agreement that includes the following:

- 1.)the representative may NOT also be the paid caregiver (i.e. Case Manager; Community Resource Advisor, Personal Care support worker; paid guardian) for the participant.
- 2.)role and responsibilities of being the participant’s representative
- 3.)role and responsibilities of the participant.
- 4.)role and responsibilities of the agency, including whether the Financial Management entity will serve as the common law employer on behalf of the participant
- 5.)a statement that the person agrees to be the participant’s representative, understands and accepts the role and responsibilities related to the role, and will abide by program policies and procedures
- 6.)the representative must include the participant as fully as possible in the decision making process related to the services and supports the participant receives and those who provide them.
- 7.)be approved and agreed upon by the participant to act in this capacity

The case manager will monitor the assistance to the participant given by the representative on an ongoing basis and is responsible for assuring that the representative acts in the best interest of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Individual Goods and Services (self direction only)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home and Community Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Modifications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual and Caregiver Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

North Carolina will utilize an RFP (Request for Proposal) process to select Financial Management Services(FMS). Waiver participants who choose to self direct must receive FMS only through an entity selected by the RFP process. The Financial Management Services agency will sign the provider agreement with the Department of Health and Human Services.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS can not bill more than 100 units (average of 25 hours for 12 months) per self directed participate per waiver year. The exceptional request for additional units of service will required DMH/DD/SAS approval.

Payment for the administrative activities will be on a fee for service basis.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

*Deduction of all required federal, state, and local taxes, including unemployment fees, prior to issuing reimbursement or paycheck;

*Administration of benefits for individual provider

* advising consumer on need and availability of insurance

* verifying qualifications of professional staff and vendors

* conducting criminal background checks

* driver's license checks, if the support worker will be required to drive

* other background checks and age verifications of providers of self directed services.

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State DHHS- Division of Mental Health/Developmental Disabilities and Substance Abuse will be the responsible governmental entity responsible for monitoring and maintenance of the contract with the Financial Management Entity.

Standard contract monitoring principles will apply including:

- Quarterly on site visits with the FMS to review the business flows and quality measures developed by the FMS to the standards of the Division.

- Monthly review of Financial Review Statements
- Annual survey to the participants who are self directing to ascertain issues, trends or areas needing corrections
- Division review of the quality standards developed by the FMS
- Review of the FMS customer service calls/complaints on a monthly basis

A report will be generated on a quarterly basis by the contract manager at the Division of Mental Health/ Developmental Disabilities/Substance Abuse Services indicating the results of the Quality Review of the FMS. If there are significant concerns of customer service or fiscal integrity, intervention by contracted agency will occur and sanctions, including monetary or termination of contract will be implemented, if warranted.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services will provide information to the Division of Medical Assistance regarding the performance of the FMS. The Division of Medical Assistance will monitor the oversight of the Division of Mental Health, Developmental Disabilities and Substance Services' management of the FMS. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services will complete the following;

- Quarterly on site visits with the FMS to review the business flows and quality measures developed by the FMS to ensure adherence to the standards and requirements of the Department of Health and Human Services.
- Monthly review of Financial Review Statements
- Annual survey to the participants who are self directing to ascertain issues, trends or areas needing corrections
- Review of the quality standards developed by the FMS
- Review of the FMS customer service calls/complaints on a monthly basis

A quarterly report will be generated and provided to the Division of Medical Assistance, by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, indicating the results of the Quality Review of the FMS. The aggregate information will be used to determine if there are significant concerns of customer service or fiscal integrity, intervention by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will occur and sanctions, including monetary or termination of contract will be implemented if warranted. Additionally, each participant and their respective support team will be contacted via a written survey at least annually to obtain information on quality of services and supports by the FMS. At any time, the participant can contact the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Customer Service line to file any complaint against their service providers including the FMS. The contact information will be readily available to each participant given at their monthly monitoring visits by their case manager.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case Management will be provided outside the Waiver through the NC State Plan Amendment. Case managers will inform participants and families of the option to self direct during the assessment and person centered planning process. Participants and /or family members will be informed of all of the roles and responsibilities associated with a self directed model including:

- explain the methodology for resource allocation, total dollar value of the allocation (not to exceed \$17,500.00 in a waiver Fiscal year)and mechanisms available to the individual/representative to modify their individual budget.
- Assess and address individual risks
- Monitor the participants' situation to assure quality care and the health, safety, and well being of the person as well as the continued appropriateness of services and supports. This includes the monitoring of:
 - the person centered plan
 - resource allocation model
 - individualized budget
 - financial management services

- the provision of Community Resource Advisor services.

- Identify the need for a representative for the participate who desires to direct his/her own services and supports, and assure that the representative meets established criteria to assist the participate to self direct their supports/services
- Ensure that the Person Centered Plan identifies how emergency back-up services will be furnished for workers employed by the individual, and authorize the provision of on-call emergency back-up services.
- Recognize and report critical incidents
- Assist with grievances and appeals
- Assist and support the participant/family in transitioning to the provider directed model of the Supports waiver if the participant/family decides that they no longer desire to continue to self direct their supports/services or for those participates who have been unable to maintain budget authority.
- Monitor the need for enhanced supports/services which may no longer be maintained under the allocation of the Supports waiver allocation of \$17,500.00

Waiver Service Coverage. Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Goods and Services (self direction only)	<input checked="" type="checkbox"/>
Vehicle Adaptation	<input checked="" type="checkbox"/>
Day Supports	<input checked="" type="checkbox"/>
Adult Day Health	<input checked="" type="checkbox"/>
Behavior Consultation Service	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>
Specialized Consultative Services	<input checked="" type="checkbox"/>
Crisis Services	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>
PERS (Personal Emergency Response System)	<input checked="" type="checkbox"/>
Long Term Vocational Supports	<input checked="" type="checkbox"/>
Home and Community Supports	<input checked="" type="checkbox"/>
Specialized Equipment and Supplies	<input checked="" type="checkbox"/>
Home Modifications	<input checked="" type="checkbox"/>
Crisis Respite	<input checked="" type="checkbox"/>
Personal Care	<input checked="" type="checkbox"/>
Augmentative Communication Devices	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Individual and Caregiver Training	<input checked="" type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

If a participant no longer chooses to self direct services, the case manager will assist the participant in identifying provider directed services available to meet the needs of the participant. The case manager is responsible for coordinating this process with the LME, Financial Management entity and the chosen service providers.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Participants who choose to self direct will receive monthly monitoring visits from the case manager to ensure that needed services and supports are being provided in accordance with the Person Centered Plan. A face to face contact with the individual and the participant's representative, if the participant has a representative, will be made to review the Person Centered Plan and the performance of the Community Resource Advisor.

If problems arise related to self direction that may impact health and safety, the case manager will work with the participant and/or the representative to resolve the issues. The case manager will work to identify additional supports in self direction, including working with the Financial Manager and Community Resource Advisor.

Due to the nature of the self directed model it is inherent that the participant be able to identify the type of support, frequency, and duration of the supports they need. Assistance will be given to the participant by the Community Resource Advisor, who is knowledgeable in the non traditional delivery of services and supports, which is knowledgeable and engaged with the non disabled community and has a strong aptitude for networking and assisting others with learning skills related to networking and community integration. The Community Resource Advisor will inform the LME and the Financial Manager and assist the participant in identifying provider directed services and supports that will meet the needs of the participant.

Once a participant terminates from the self directed model, Community Resource Advisor will no longer be an available service under the provider directed model.

Any time that the utilization of funds exceeds planned expenditure levels, the Financial Manager will notify the individual, legally responsible person and the case manager. The case manager will work monthly with the participant, and/or representative to resolve issues related to expenditures, and identify additional supports in participant direction.

Within a 6 month period of time, if the participant and/or their non paid representative, exceeds the projected utilization of the budget within 4 of 6 months. The case manager will meet with the participant and /or representative monthly to track utilization and provide

any technical assistance needed.

The participant will be offered:

- 1) further training on managing a personal budget and what a participant’s responsibility is within the self directed model; and
- 2) if a participant does not have a non paid representative, they will be encouraged to work with an appropriate non paid representative; and
- 3) if they decline these 2 types of assistance, termination from the self direction model will occur and the participant will be able to continue in the Supports Waiver utilizing the standard provider driven service delivery model.

In the event that the utilization of funds continues to exceed planned expenditure levels and the participant is no longer able to maintain budget authority, the case manager will convene a meeting to review the Person Centered Plan as appropriate and the choice of self-direction of services and budget authority may be terminated.

The participant, who due to circumstances including mismanagement of funds, will have the option to reinstate the use of the self directed service model after 6 months of termination of the option to use the self-directed service model. Participants will be required to completed mandated training to ensure the skills needed to be successful at self-direction.

The termination of the option to use the self-directed service model is not a reduction, suspension or termination of services. It is a change of a service delivery model, which is intended to offer to those participants with the appropriate support, if needed, the opportunity to direct the “how” of their services. If a participant does not follow the required process/procedures to ensure financial integrity they will need to receive the necessary support to ensure success with the self direction of their services. Participants will continue to receive services and support within the Supports waiver. The termination self directed services does not result in the termination, reduction or suspension of supports, therefore no fair hearing/appeal rights are required.

The case manager will assist and support the individual/family in transitioning to the provider directed model in the Supports waiver; another North Carolina Waiver or to an ICF-MR facility. In all cases the case manager will be responsible for working with the participant and/or the representative in identifying service providers and ensuring that there is no lapse in service delivery as a result of termination of self direction option.

Participants who demonstrate the inability to self direct waiver services whether due to misuse of funds, consistent non adherence to program rules or an ongoing health/safety risk, will be required to select a representative to assist them with the responsibilities of self direction. If a participant refuses to select a representative, or if the participant loses a representative and cannot locate a replacement, they will be required to transfer to the traditional model of provider directed services. Case managers and the Community Resource Advisor will assist the participant in the transition. Finally, any confirmed activities which are determined to be illegal, or a fraudulent use of Medicaid funds will result in immediate termination from self direction and the participant will be moved to a provider directed model.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	<input type="text"/>	2 <input type="text"/>
Year 2	<input type="text"/>	50 <input type="text"/>
Year 3	<input type="text"/>	75 <input type="text"/>

Appendix E: Participant Direction of Services

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

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The model of self direction the State of North Carolina is one of agency of choice and the FMS entity will serve as the employer of record for individual providers selected by the participant, pending the meeting of employment verification standards noted in Appendix E-1 iii.

The participant, will be considered the managing employer of all staff who they chose to engage to work for them for services which are designated as being self directed. The Community Resource Advisor will be charged with assisting the participant in the responsibilities of all employer related functions, including the role and responsibility of self directing services(financial accountability including payback for non authorized services); interviewing skills; ensuring the staff have the proper individualized training; employee evaluation and if needed, how to terminate someone's employment. Refer to Appendix E:2 ii for additional responsibilities for a participant who self directs.

The FMS entity is selected through an RFP process and holds a binding contractual relationship with the DHHS. Standard contract monitoring will occur and DHHS-DMH/DD/SAS will be responsible to provide contract oversight to the FMS.

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:
- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*
- Reallocate funds among services included in the budget**
 - Determine the amount paid for services within the State's established limits**
 - Substitute service providers**
 - Schedule the provision of services**
 - Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
 - Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
 - Identify service providers and refer for provider enrollment**
 - Authorize payment for waiver goods and services**
 - Review and approve provider invoices for services rendered**
 - Other**

Specify:

Appendix E: Participant Direction of Services

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

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

A participant, who has received waiver services in the past year, will have their individualized budget based upon the previous years cost summary of services. The projected annual expenditures for CAP MRDD waiver services from cost summary will be the individual resource allocation.

For participants choosing to self-direct services with less than 12 months of CAP MRDD services the maximum resource allocation amount would be based upon the person centered plan. The participant and their family will work with the case manager to develop a detailed individual budget as part of the person centered plan. The projected annual expenditures for CAP MRDD waiver services from cost summary will be the individual resource allocation.

Participants will have maximum flexibility in the utilization of resources delineated in the their individual budget, within the confines of the Medicaid program, however, persons choosing the option to self direct will be agreeing to operate within the agreed individual budget, within the confines of the Medicaid program . While the person centered plan may be changed during the cost summary must not exceed the maximum allowed resource allocation.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Each individual in the Supports waiver will be provided a resource allocation prior to the PCP approval. Determination of the resource allocation is based on the process noted in E.2. ii.

For those participants who chose not to self direct, the individualized budget will be based upon the participants needs as reflected in the Person Centered Plan and will not exceed \$ 17,500.00 per waiver fiscal year.

As with any model for predicting the amount of resource allocations, this model has limitations. In light of this, a process will be in place to mediate individual cases where the predicted amount is not in line with the actual support needs identified in the person centered planning process. The person centered planning process will be central to the mediation process and will include the following steps:

- 1.The maximum resource allocation amount is predicted for a participant based on the model described in E.2 ii.
- 2.The case manager will facilitate the person centered plan with the participant and other individual's requested by the participant. The Person Centered Plan process will result in an individual budget that does not exceed the allocation stated.
3. The Person Centered Plan, including the cost summary is then submitted to the contracted vendor service for final review, approval and service authorization.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The case manager, in collaboration with the Financial Management Services entity, is responsible for monitoring the

expenditure of funds authorized in the person centered plan and cost summary. Once the cost summary is established, the case manager is responsible for the following functions in, order to prevent premature depletion of the budget and address potential health and safety issues associated with budget underutilization or over utilization:

- 1.Meet with the individual at least monthly to review the budget and corresponding expenditures. The case manager will monitor expenditures on a monthly basis through review of reporting for each individual self-directed budget maintained by the Financial Manager.
- 2.Assist the individual to work with the Financial Manager to monitor and manage the cost summary.
- 3.Assist the individual to negotiate with service providers around service provision to ensure that services are provided in accordance with the Person Centered Plan and the cost summary.

The entity will provide the following functions:

1.Establish accounting and information systems necessary for processing and paying individual providers as specified in the participant's and service authorizations, and establishes the reporting functions and the internal controls necessary to track and manage these functions. These controls include ensuring that payment is made only for authorized service units, no payment is made beyond the number of units authorized, that payments are made at the authorized service unit rate and that the participant or representative sign the timesheet or invoice indicating that the services were performed as indicated in the Person Centered Plan.

2.Establish and maintain a system for tracking service units and expenditures for services. The system will include individual participant accounts.

3. Prepare and submit monthly, quarterly and annual reports that detail authorized units of services expenditures, and non-expended authorized units. Information specific to participants will be submitted to those participants/legally responsible persons and their case manger and Community Resource Advisor. Aggregate reports shall be submitted to the Local Management Entities who are responsible for participant services and monitoring of the local aggregate budget.

Any time the utilization of funds exceeds the planned expenditure level, the Financial Management Services Entity will notify the individual, legally responsible person and the case manager. In the event that the utilization of funds continues to exceed planned expenditure levels, the case manager will convene a meeting to review the person centered plan, determine any additional supports that are needed; and the choice of self-direction may be terminated.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Persons whose requests for waiver services are denied, reduced, terminated or suspended; denied the provider of their choice; or, denied LOC are issued a written notice that states the adverse action, citation supporting the action, and due process of appeal rights for a fair hearing or formal appeal conducted by the Office of Administrative Hearings (OAH). This notice must be mailed at least 30 days prior to the effective date of the adverse action. If the recipient chooses to appeal the decision, he/she has 30 days from the date the notice is mailed to appeal the decision. Should the recipient appeal within the mandated timeframe and should the recipient currently be receiving services, those services continue for the pendency of the appeal. If a consumer is not receiving services, OAH will expedite the hearing request. N.C.G.S. 150B-31.2 (c) allows each recipient to be offered mediation prior to a fair hearing. This mediation takes place outside of OAH. If the mediation successfully resolves the case to the recipient's satisfaction, the case is dismissed. Should the recipient reject the offer of mediation or the mediation is unsuccessful, the case proceeds to fair hearing.

In addition to individual notices of adverse actions taken, the state provides education about due process and appeal rights as specified below.

Any contract vendor, each LME, designated Lead Agency, and Case Manager will have access to the information about the appeal process and it contains, as a minimum:

- the right to a Fair Hearing;

- the method for obtaining a Fair Hearing;
- the rules that govern representation at Fair Hearings;
- the right to file grievances and appeals;
- the requirements and timeframes for filing a grievance or appeal;
- the availability of assistance in the filing process;
- the toll-free numbers that the individuals can use to file a grievance and/or appeal by phone;
- rights, procedures and timeframes for voicing or filing grievances and appeals or recommending changes in policy and services.

Each participant will receive a copy of their rights at the time of eligibility screening for home and community based waiver services. The case manager is responsible for providing support and assistance to the participant, when needed, in understanding and navigating the Fair Hearing process. This process will be reviewed on annual basis at the time for the Continued Need Review.

Information re a fair hearing for Medicaid covered services that are denied, reduced, terminated, or suspended is found in the Medicaid Consumer Guides. These Guides are distributed by the local DSS staff during the Medicaid eligibility determination process and are found on the DMA website. The Guides describe due process and how a recipient can request a fair hearing for any adverse action taken or when a response to a request for service has not been issued in a reasonable period of time.

General information about due process rights and fair hearings is included in recipient MID card mailings at least quarterly.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

N.C.G.S. 150B-31.2(c) allows each recipient to be offered mediation prior to a fair hearing. When an appeal request for a fair hearing is received by OAH, OAH notifies the Mediation Network of North Carolina (independent of OAH). The Network has five days to contact the recipient to offer mediation in an attempt to resolve the dispute. Mediation must be complete within 25 days of submission of the request for appeal to OAH. If the mediation successfully resolves the case to the recipient's satisfaction, the case is dismissed. Should the recipient reject the offer of mediation or the mediation is unsuccessful, the case proceeds to fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

Administrative Rule 10A NCAC 27G .0609 requires each LME to report to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) on a quarterly basis in an electronic format provided by the Secretary on all complaints made to the LME. Accordingly, the Local Management Entity (LME) Complaint Reporting System was initiated in September 2006. The goal of this vital reporting system is to use the information gathered to improve the mental health, developmental disabilities and substance abuse service system. The Division of Mental

Health/Developmental Disabilities/Substance Abuse Services shall provide the policy for consumer complaints to the LME. All LMEs are responsible for aligning their policies regarding consumer complaints to this policy. The LME is responsible for the operation of the grievance/complaint system. This complaint policy and processes falls outside the scope of the Fair Hearing process.

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

Policy for Consumer Complaints to an Local Management Entity

For the purposes of this policy, a complaint is an expression of concern in writing or orally regarding rights, services or administrative issues that the complainant perceives as a problem.

I. Potential Rights Violations

1. A consumer, guardian, staff person or other individual observing the alleged violation may file a complaint against a service provider or LME staff to the LME. DMH/DD/SAS shall provide LMEs with a listing of standard elements to be collected for each complaint. The LME's Customer Service and Consumer Rights office (hereinafter CSR) staff must assist a complainant who requests assistance in filing the complaint and also provide consumer information materials describing the complaint process and how to contact advocacy groups.
2. Complaints are filed to the LME's CSR office.
3. The CSR must notify a complainant within 5 days of receipt of the complaint whether the complaint will be addressed directly by a conflict resolution process or by conducting an investigation of the allegation(s).
4. In CONFLICT RESOLUTION PROCESSES (Informal Reviews), the LME shall offer the complainant the option of accessing the provider's internal complaint process or conflict resolution services offered by the LME.
 - (a) Consumers are not required to participate in the provider's conflict resolution or complaint process before submitting a complaint to the LME.
 - (b) If the issue is resolved either by the provider's or the LME's conflict resolution process, the LME documents the results.
 - (c) The informal review shall be completed within 10 days after the complaint is received by the CSR.
 - (d) If the issue is not resolved, the complainant may file a complaint to the LME Human Rights Committee within 10 days from the date of the completion of the conflict resolution process.
 - (e) If the need for an investigation is revealed during conflict resolution, the LME will begin the investigation or refer the matter to the appropriate State or local government agency.
 - (f) The Human Rights Committee's decision shall be dated and mailed to the complainant by the CSR within 15 days from receipt of the complaint.
5. In INVESTIGATIONS, the LME must adhere to all procedures and deadlines that apply to the complaint and investigation process for 10A NCAC 27G .0606 (pursuant to SB 163), the relevant portion of which is summarized below in (a) to (f):
 - (a) The LME must complete the complaint investigation within 30 days of the date of the receipt of the complaint and submit a report of investigation findings to the complainant, the provider or to the appropriate supervisory staff for complaints regarding LME program staff and to the consumer's home LME, if different.
 - (b) The report shall be submitted within 10 days of the date of completion of the investigation.
 - (c) If a violation is found, the LME shall require remedial action through a plan of correction submitted by the provider within 10 days from the date the provider receives the complaint investigation report.
 - (d) The LME shall review and respond in writing to the provider's plan of correction with approval or a description of additional required information to the provider within 10 days of receipt of the plan of correction.
 - (e) If a plan of correction is needed, it shall be implemented in a timely manner not exceeding 60 days from the date of the complaint investigation report. The LME shall verify that the corrected actions cited in the investigation report were implemented no later than 60 days from the date the plan of correction is approved.
 - (f) The LME shall comply with 10A NCAC 27G .0606 (pursuant to SB 163) regarding the referrals of LME investigations to the State or local agency responsible for regulation or oversight of the matter.
 - (g) The complainant who disagrees with the results of the LME actions may file a complaint to the Human Rights Committee within 10 days from the receipt of the LME investigation report or the LME approval of the provider's corrective action plan. The complaint is limited to the complaint record and allegations that the investigation and/or corrective actions are inadequate or not completed in a timely manner.
 - (h) The Human Rights Committee shall notify the complainant within 5 days from receipt of the complaint whether the complaint meets the above criteria. If the complaint is accepted by the Human Rights Committee, the CSR shall send the Human Rights Committee's written decision within 15 days from receipt of the complaint to: 1) uphold the investigation findings and corrective action plan, 2) return the investigation findings and corrective action plan to the CSR for a reinvestigation, 3) uphold the investigation findings and corrective action plan with specified changes.

II. Complaints Regarding Clinical Service Decisions

The procedures shall be outlined in the LME Utilization Management Policy.

A complaint concerning a clinical decision regarding non-Medicaid services may be filed either by a consumer, legally responsible person or any other individual who does not have a conflict of interest. Consumers shall be advised that filing a complaint in no way guarantees the consumer the specified service regardless the outcome of the review. DMH/DD/SAS shall provide LMEs with a listing

of standard elements to be collected for each complaint. The CSR staff must assist a complainant who requests assistance in filing the complaint and also provide consumer information materials describing the complaint process and how to contact advocacy groups.

III. Complaints Regarding Administrative Issues and Service Quality

A complaint regarding administrative issues or service quality may be filed by a consumer, legally responsible person, staff, or any other individual without a conflict of interest. The CSR staff must assist a complainant who requests assistance in filing the complaint and also provide consumer information materials describing the complaint process and how to contact advocacy groups.

1. Receipt and Documentation of Administrative or Service Quality Complaints:

The CSR reviews and documents the complaint. The CSR shall acknowledge receipt of the complaint the same or next business day following the date the complaint was received. The CSR shall describe the informal review process to address the specific complaint and provide contact information to the complainant for questions regarding the complaint.

2. Review Levels:

Level I: Informal Review Process: The CSR shall implement an informal process to review the complaint within 10 days from the date the complaint was received orally or in writing by the CSR and ensure that the complainant is given full opportunity to represent his/her concern. A decision regarding the complaint shall be dated and mailed to the complainant by the CSR within 2 days of the date the review was held.

Level II: A complaint regarding a Level I decision must be received orally or in writing by the CSR within 10 days of the date indicated on the Level I written decision letter. The CSR shall acknowledge receipt of the complaint the same or next business day following the date the complaint was received. The LME Director shall review the complaint. The CSR shall send the LME Director's written decision to the complainant within 10 days from the date the complaint was received by the CSR.

The letter shall be mailed no later than the next day following the Level II review decision.

Utilization Management Complaints to Area/County Programs

Note: LMEs may include this section in their Utilization Management Policy. The content of this section and sections I and III shall be available and easily accessible to consumers in a consumer-friendly handbook.

A complaint concerning a clinical decision regarding non-Medicaid services may be filed either by a consumer, legally responsible person or any other individual who does not have a conflict of interest. Consumers shall be advised that filing a complaint in no way guarantees the consumer the specified service regardless the outcome of the review. DMH/DD/SAS shall provide LMEs with a listing of standard elements to be collected for each complaint. The CSR staff must assist a complainant who requests assistance in filing the complaint and also provide consumer information materials describing the complaint process and how to contact advocacy groups.

1. Complaint Information: The LME shall provide consumers and/or their legal representatives with written information about filing a complaint regarding clinical authorizations when the consumers and/or legal representatives: 1) enter services, 2) disagree with the person-centered planning team's or the utilization management (UM) clinical recommendations, or 3) at any other time the consumers and/or legal representatives request such information.

2. A letter shall be dated and mailed no later than the next day following the team meeting or the UM decision to deny authorization. The letter shall state that the requested service may be authorized if the prior denial is overturned by the subsequent LME clinical review.

- The letter shall include information to the consumer and/or his or her legal representative regarding the reason for the decision and any available options or considerations while the complaint is under review.

3. Filing Requirements:

The complaint must be received orally or in writing by the CSR within 10 days of the date of the letter.

4. Clinical Reconsideration Review:

The LME Medical/Clinical Director or designee with credentials comparable to the prior reviewer shall complete a clinical review of the complaint and may uphold or overturn the original decision within 5 days from receipt of the complaint. The LME Medical/Clinical Director or designee shall review the complaint based on the following criteria:

The decision described in the letter is not consistent with established service definitions.

The decision described in the letter is not clinically appropriate to the complainant's situation.

Decision Requirements: The LME Medical/Clinical Director or designee notifies the complainant and the CSR of the decision within 2 days from the date of the clinical review. The decision letter to the consumer shall be mailed no later than the next day following the LME review decision. In cases in which the reviewer overturns the original decision, the decision letter shall state the date on which the denied service shall be authorized or the date on which the suspended, reduced or terminated service shall be reinstated. The LME shall develop an expedited clinical review process to address complaints regarding emergency services.

Foot Notes

1 Including, but not limited to, G.S.122C-Article 3, NCAC T10A 26B (Confidentiality Rules for MH/DD/SA Facilities and Services) and 27C, 27D, 27E, 27F (Participant Rights Rules in Community MH/DD/SA Services). Each LME is developing these functions which include customer service, advocacy and investigation. All days are calendar days. If necessary, deadlines fall on the first business day after a weekend or holiday.

4 The LME or the complainant may request technical assistance from the DMH/DD/SA Customer Service and Community Rights Team. No formal resolution or decision shall be rendered by DMH/DD/SA in this process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

North Carolina Administrative Code 10A NCAC 12G.0603 requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the Division of Mental Health, Developmental Disabilities and Substance Abuse Services-coordinated system for responding to and reporting critical incidents and other life endangering situations. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

Service providers are required to respond to all incidents by:

- Insuring the safety of consumers and others
- Documenting the incident and steps taken to remedy the situation
- Analyzing incident trends as part of the agency's quality improvement process

Incidents are divided into three levels of severity, which determine the intensity and breadth of the response.

• **Level I** – the least severe – includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events but that can signal the potential for more serious future problems if not addressed. These incidents are reviewed during provider monitoring reviews by the LME which oversee providers in the geographic catchment area.

Provider agencies review incidents at level I internally and report aggregate numbers of Level I incidents, identified trends and activities being undertaken to address identified problems to the LME quarterly

• **Level II** includes incidents with immediate or potentially serious adverse consequences to the participant or others, including such events as injuries, abuse allegations, and use of restrictive interventions.

Provider agencies report Level II incidents to the LME within 72 hours. The LME reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities. When there is reason to believe that an adult or child may be abused, neglected or exploited and in need of protective services, the incident is also reported to the local Department of Social Services and to the state Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.

• **Level III** includes incidents with the most severe and permanent consequences – death or permanent impairment of a participant or caused by a consumer. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and LME of steps taken. Death from suicide, accident, homicide or other violence report to Host LME; Home LME; to DMH/DD/SAS and to Division of Health Service Regulation (122C-Licensed providers only) a verbal report immediately followed up with a written report within 72 hours. Death within 7 days of seclusion or restraint report to Host LME; Home LME; to DMH/DD/SAS and to Division of Health Service Regulation (122C-Licensed providers only). A written report immediately. If the host LME is not satisfied with a provider agency's response to an incident or its ability to prevent future incidents, the LME or host LME can refer the incident to the Division of MH/DD/SAS or Division of Health Service Regulation (if licensed) for further review. Each LME analyzes trends for their areas and the Division of MH/DD/SAS analyzes and reports statewide trends summarizing deaths, grouped by LME. The Division of MH/DD/SAS report describes the common trends and activities being taken to minimize the occurrence of adverse events and prevent similar occurrence.

Provider agencies report Level III incidents to both the LME and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual). LMEs report information on Level II and III incidents to the Division of Mental Health Developmental Disabilities and

Substance Abuse Services quarterly, including aggregate numbers of types of incidents, local trends identified in the LME's analysis and actions they have taken to prevent future incidents.

The Division of MH/DD/SAS Customer Services Community Rights (CSCR) Team tracks and analyzes all complaints that come to the Division of MH/DD/SAS. Data collected on complaints include complainant and participant information, the type of complaint, and results of attempts to resolve the complaint. The Division of MH/DD/SAS Customer Services Community Rights (CSCR) Team has collaborated with LME's to develop a listing of standard elements to be collected for each complaint. The Client Rights Committee (at the LME's) reviews incidents and participant complaints, including alleged violations of the rights of individuals or groups; cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive procedures, and failure to provide needed services that are available. The Client Rights Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action. The Client Rights Committee makes recommendations to the Area Board and may make report to local Dept of Social Services and other applicable licensing agencies such as Division of Health Service Regulation, and Division of Aging.

Local mortality reviews are conducted by the provider agency, according to the Level III guidelines established in 10A NCAC 27G .0603. This rule requires that the provider agency immediately attend to the health and safety needs of any individuals involved in the incident, determine the cause of the incident, develop and implement measures to prevent similar incidents, secure the record, convene a peer review team within 24 hours of the incidents and immediately notifying the host LME, parent/legal guardian and any other authorities required by law (such as the Division of Social Services, Division of Health Service Regulation or a licensing agency). The provider's peer review committee must issue a report concerning the incident to the provider, the host LME and the consumer's home LME. The host LME provides oversight of this mortality review process.

Immediately following a Level III death (such as a death from an accident, homicide/death, suicide or unknown cause), the provider agency must submit an incident report to the home LME, host LME and the Division of MH/DD/SAS. If the host LME is not satisfied with a provider agency's response to an incident or its ability to prevent future incidents, the LME or host LME can refer the incident to the Division of MH/DD/SAS or Division of Health Service Regulation (if licensed) for further review. Each LME analyze trends for their areas and the Division of MH/DD/SAS analyzes and reports statewide trends summarizing deaths, grouped by LME. The Division of MH/DD/SAS report describes the common trends and activities being taken to minimize the occurrence of adverse events and prevent similar occurrence.

The Division of MH/DD/SAS Accountability Team and DMA's Behavioral Health Unit ensure the viability of these systems through routine on-site reviews of the LMEs' and providers' responses to reported incidents and complaints. The Department of Health and Human Services (DHHS) Performance Contract with the LME's requires that the LME produce reports and use incident reporting data for planning, decision making, and improvement. The reports will analyze and summarize patterns and trends. Trends related to consumers include incidents and client rights. LME's must report quarterly

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

Administrative rules require LME to ensure that consumers are knowledgeable about their rights and about provider and LME complaint processes. The Division of MH/DD/SAS has established a standardized procedure for receiving and responding to complaints. The LME is the local hub for receiving complaints about service provision. The Division of MH/DD/SAS website has a page devoted to client rights and the notice of appeals process. A brochure is being developed and will be given to each participant upon waiver enrollment

Provider Agencies are required to explain to consumers of their rights. The Provider Agency will also explain to the consumers the rules that they are expected to follow as well as the penalties for not following the rules. The explanations shall be in a manner consistent with the level of comprehension or the participant legally responsible person. The Provider Agency will provide the participant or their legally responsible person with a written summary of their rights.

All individuals who participate in the waiver will receive information regarding protections from abuse, neglect, and exploitation and the process for notifying appropriate authorities when abuse, neglect or exploitation is experienced at the time of development of the person centered plan. This process is facilitated by the case manager.

In addition, Case managers and Consumer Resource Advisor are an important source of education and advocacy for individuals who choose to self-direct in this waiver. Consumer Resource Advisor will provide ongoing education and training and support on an as needed basis regarding what constitutes abuse, neglect, and exploitation and to whom those events are reported. The NC Department of Health and Human Services operates a toll free Care Line where participants can receive additional information or assistance, if needed. These lines have the capacity to assist participants that are primarily Spanish speaking and hearing impaired.

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

North Carolina Administrative rules require all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in a Division of MH/DD/SAS coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The LMEs and the Division of MH/DD/SAS provide oversight to the reporting and response to critical incidents or events that affect waiver

participants.

The NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services is the Lead Agency for statewide operations of this waiver and has ultimate responsibility for oversight of reporting of and response to critical incidents. The NC Division of Medical Assistance oversees the overall operation of the waiver according to federal and state guidelines. The Divisions cooperate in the operation of the waiver. However, there is responsibility across multiple entities to insure that health and safety needs are addressed at all levels:

Provider Agencies will:

- Complete and submit Incident Reports as required by DHHS rules
- Complete and submit Death Reports as required by DHHS rules
- Contact the case manager if there are any concerns about the health or safety of the individual receiving services
- Inform participant of his/ her right to contact Disability Rights (the state's protection and advocacy system).

Provider agencies review incidents at level I internally and report aggregate numbers of Level I incidents, identified trends and activities being undertaken to address identified problems to the LME quarterly. Level I – the least severe – includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed. These incidents are reviewed during provider monitoring reviews by the LME which oversee providers in the geographic catchment area.

Provider agencies report Level II incidents to the LMEs within 72 hours. The LMEs review these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities. When there is reason to believe that an adult or child may be abused, neglected or exploited and in need of protective services, the incident is also reported to the local Department of Social Services and to the state Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation. Level II includes incidents with immediate or potentially serious adverse consequences to the participant or others, including such events as injuries, abuse allegations, and use of restrictive interventions.

Provider agencies report Level III incidents to both the LME and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual). LME's report information on Level II and III incidents to the Division of Mental Health Developmental Disabilities and Substance Abuse Services quarterly, including aggregate numbers of types of incidents, local trends identified in the LME's analysis and actions they have taken to prevent future incidents. Level III includes incidents with the most severe and permanent consequences – death or permanent impairment of a participant or caused by a consumer. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and LME of steps taken.

Local mortality re

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

North Carolina Administrative rules require all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in a Division of MH/DD/SAS coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The LMEs and the Division of MH/DD/SAS provide oversight to the reporting and response to critical incidents or events that affect waiver participants.

The NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services is the Lead Agency for statewide operations of this waiver and has ultimate responsibility for oversight of reporting of and response to critical incidents. The NC Division of Medical Assistance oversees the overall operation of the waiver according to federal and state guidelines. The Divisions cooperate in the operation of the waiver. However, there is responsibility across multiple entities to insure that health and safety needs are addressed at all levels:

The Case Manager will:

- Conduct a quarterly in home face-to-face visit as well as face to face visits, at a minimum once a month, with participants in a variety of settings in which non-paid and paid services being rendered with the individual to inquire about any concern or problem with service provision and/or health and safety.
- Reassess each individual's needs at least annually and develop a revised person centered plan based on that reassessment.
- Follow-up and resolve any issues related to the individual's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME.

Community Resource Advisor will:(for those participating in self direction only)

- Contact the case manager if there are any concerns about the health or safety of the individual receiving services
- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Individuals will also be notified of grievance and complaint resolution processes
- Follow-up and assist with resolution of any issues related to the individual's health, safety, or service delivery
- Contact the Customer Services Community Rights (CSCR) Team to generate complaint on behalf of the individual participating in

the waiver regarding their services or supports or health and safety, dissatisfaction with Case Management services, Provider agency services, and or Representative services.

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of restraints or seclusion

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

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

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

Use of restraints or seclusion is allowed with this waiver. Behavior interventions are only used as a last resort and are subject to rigorous oversight. All Provider Agencies, facility based and non facility based, will follow the rules and protections outlined in NC Administrative Rules 10A NCAC 27E. N.C. Administrative rule 10A NCAC 27E .0102 indicates that the following procedures are prohibited: (a) any intervention which would be considered corporal punishment under G.S. 122C 59, (b) the contingent use of painful body contact, (c) substances administered to induce painful bodily reactions, exclusive of Antabuse, (d) electric shock (excluding medically administered electroconvulsive therapy); (e) insulin shock; (f) unpleasant tasting foodstuffs; (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the participant for the purpose of reducing the frequency or intensity of a behavior. Rules also require that a facility review of a participant's health history or conduct a comprehensive health assessment upon admission to the facility in order to identify any pre-existing medical conditions or any disabilities or limitations that would place the participant at a greater risk during the use of an intervention. Restrictive interventions may be used only as part of a behavioral plan or in emergency situations where the participant is in imminent danger of abuse or injury to self or other persons, or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by an Intervention Advisory Committee prior to implementation. Utilization of any restrictive procedure will be documented on the DHHS Restrictive Intervention Details Report. This report documents the reasons for the use of the intervention and the health status of the individual before, immediately after, and 30 minutes after the use of the restrictive intervention. This report is submitted within 72 hours of the use of a restrictive intervention to the LME. Per Division of MH/DD/SAS policy and administrative rules, 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in methods of preventing and alternatives to use of physical restraint/isolation time out. Prior to providing services to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training. Training curricula must be competency-based, must include components identified by the State, and must be approved by the State. Certain Individuals, such as the legal guardian and the treatment team, must be notified following any restrictive intervention. Emergency restrictive interventions may only be employed up to 15 minutes without further authorization. The use of any restrictive intervention must be discontinued immediately at any indication of risk to the participant's health or safety or immediately after the participant gains behavioral control. Service Providers must maintain documentation of initial and annual refresher training, which may be reviewed by State staff at any time. There are specific criteria listed in the rules regarding the structure of a seclusion area.

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

NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to participate in a Division of MH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The LMEs and the Division of MH/DD/SAS provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the LME. If the provider agency has not implemented or documented this appropriately, the LME will request a plan of correction from the provider. If the agency is licensed through the Division of Health Service Regulation, the LME may contact the Division of Health Service Regulation regarding any concerns

Appendix G: Participant Safeguards

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

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

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

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

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

All Provider Agencies, facility based and non facility based, will follow the rules and protections outlined in NC Administrative Rules 10A NCAC 27E.

Behavior interventions are only used as a last resort and are subject to rigorous oversight. N.C. Administrative rule 10A NCAC 27E .0102 indicates that the following procedures are prohibited:

- (a) any intervention which would be considered corporal punishment under G.S. 122C 59,
- (b) the contingent use of painful body contact,
- (c) substances administered to induce painful bodily reactions, exclusive of Antabuse,
- (d) electric shock (excluding medically administered electroconvulsive therapy);
- (e) insulin shock;
- (f) unpleasant tasting foodstuffs;
- (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and
- (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the participant for the purpose of reducing the frequency or intensity of a behavior.

Restrictive interventions may be used only as part of a behavioral plan or in emergency situations where the participant is in imminent danger of abuse or injury to self or other persons, or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by the Division of MH/DD/SAS Intervention Advisory Committee prior to implementation. Rules also require that a facility review of a participant's health history or conduct a comprehensive health assessment upon admission to the facility in order to identify any pre-existing medical conditions or any disabilities or limitations that would place the participant at a greater risk during the use of an intervention.

Utilization of any restrictive procedure will be documented on the DHHS Restrictive Intervention Details Report. This report documents the reasons for the use of the intervention and the health status of the individual before, immediately after, and 30 minutes after the use of the restrictive intervention. This report is submitted within 72 hours of the use of a restrictive intervention to the LME. Per the Division of MH/DD/SAS policy and administrative rules, 10A NCAC

27E .0107 Training on Alternatives to Restrictive Interventions prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in methods of preventing and alternatives to use of physical restraint/isolation time out. Prior to providing services to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training.

- Training curricula must be competency-based, must include components identified by the State, and must be approved by the State.

- Certain Individuals, such as the legal guardian and the treatment team, must be notified following any restrictive intervention.

- Emergency restrictive interventions may only be employed up to 15 minutes without further authorization.

- The use of any restrictive intervention must be discontinued immediately at any indication of risk to the participant's health or safety or immediately after the participant gains behavioral control.

- Service Providers must maintain documentation of initial and annual refresher training, which may be reviewed by State staff at any time.

Use of Personal, Mechanical Restraints and Seclusion is allowed with this waiver.

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

Administrative rules requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to participate in a Division of MH/DD/SAS coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues. The LMEs and the Division of MH/DD/SAS provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the LME which oversees provider in its geographic catchment area. If the provider agency has not implemented or documented this appropriately, the LME will request a plan of correction from the provider. If the agency is licensed through the Division of Health Service Regulation, the LME may contact the Division of Health Service Regulation regarding any concerns.

Each Local Management Entity (LME) is responsible for reviewing a sample of incidents and complaints, which includes unplanned and unauthorized use of restraints. If deemed necessary the Local Management Entity will investigate the incident. If the Local Management Entity has noted trends in the inappropriate use of the restrictive techniques a plan of correction may be implemented based on the outcome of the investigation. Each LME analyzes trends for their catchment area. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services analyzes and reports statewide trends grouped by LME. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services' report describes the common trends and activities being taken to minimize the occurrence of adverse events and to prevent similar occurrences.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services Customer Services Community Rights Team tracks and analyzes all complaints that come to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Data collected on complaints include complainant and participant information, the type of complaint, and results of attempts to resolve the complaint. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services Customer Services Community Rights Team has collaborated with LMEs to develop a listing of standard elements to be collected for each complaint. The LMEs' Client Rights Committee reviews incidents and participant complaints, including alleged violations of the rights of individuals or groups; cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive procedures, and failure to provide needed services that are available. The LMEs' Client Rights Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had the opportunity to take action. The LMEs' Client Rights Committee makes recommendations to the Area Board and may make a report to the local Department of Social Services and other applicable licensing agencies such as the Division of Health Service Regulation, and the Division of Aging.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

- a. **Applicability.** Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

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

Provider agencies are required to have a pharmacist or physician complete quarterly medication/ drug reviews for participants taking medications with potentially serious side effects. The results of the review are provided to the primary physician by the Case Manager. The LME reviews the report during on-site monitoring visits with the provider agency.

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

State rules and regulations outline requirements for policies and procedural precautions which must be implemented for medication management which includes prohibited practices. Individuals administering medications must be trained and privileged to do so. The provider agency is required to provide monitoring and supervision of medication administration. Medication errors are reported to the LME according to the Division of MH/DD/SAS Incident Reporting Procedure. Provider agencies are required to have a pharmacist or physician complete quarterly medication/ drug reviews for consumers taking medications with potentially serious side effects. These procedures are reviewed by the state regulatory entities during annual or complaint reviews as part of the state on-site monitoring visits with the provider agency.

Case Managers have the responsibility to be aware of medication errors through review of incident reports. Case Managers will incorporate information from incident reports into the risk assessment review.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

Not applicable. (*do not complete the remaining items*)

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (*complete the remaining items*)

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All provider agencies, licensed and unlicensed, will follow state rules and regulations outlining requirements for policies and procedures to be implemented for medication administration including self-medication. These state that all medications, prescription or non prescription, can only be administered to a participant through a doctor's order. State regulations outline procedures for the storage, labeling, administration and disposal of medication. Consumers who self-medicate are required to have an assessment on their ability to self-medicate and the physician ordering the medication must sign an order for self-administration of medication. Documentation must be maintained as outlined in state rules/regulations.

- iii. Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

Provider Agencies report medication errors to the LME who in turn report the errors to the Division of MH/DD/SAS through the Incident Reporting Procedures. Service providers are required to respond to all incidents, including medication errors, by:

- insuring the safety of consumers and others,
- documenting the incident and steps taken to remedy the situation,
- analyzing incident trends as part of the agency's quality improvement process

Provider Agencies are responsible for reporting medication errors made by participants who self administer their medications at the time the Provider Agency learns of the error.

(b) Specify the types of medication errors that providers are required to *record*:

The medication errors that Provider Agencies are required to report include: wrong medication, wrong dose, wrong time (over 1 hour from prescribed time), missed dose or medication refusals by the participant.

(c) Specify the types of medication errors that providers must *report* to the State:

Any error that results in permanent physical or psychological impairment, as determined by a physician or pharmacist, is reported to the Division of MH/DD/SAS to the Incident Reporting process. Other medication errors are reported to the Division of MH/DD/SAS in aggregate through Quality Management requirements of the LME.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Division of MH/DD/SAS monitors medication administration through the Incident reporting system. Administrative Code requires all LMEs and provider agencies to participate in a DMH/DD/SAS-coordinated system for responding to and reporting critical incidents, including medication errors, and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

The LMEs monitor medication administration through the Incident Reporting system, and provider monitoring. Incidents are divided into three levels of severity, which determines the intensity and breadth of the response:

- Level I: includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
- Level II: includes incidents with immediate or potentially serious adverse consequences to the participant or others, including such events as injuries, abuse allegations, and use of restrictive interventions
- Level III: includes incidents with the most severe and permanent consequences-death or permanent impairment. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding their safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and the LME of steps taken.

Provider agencies handle Level I incidents internally and report aggregate numbers of level I incidents, identified trends and activities being undertaken to address identified problems to the LME quarterly.

Provider agencies report Level II incidents to the LME within 72 hours. The LME reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities.

LMEs report information on Level II and III incidents to the DMH/DD/SAS quarterly, including aggregate numbers of types of incident, local trends identified in the LME's analysis and actions they have taken to prevent future incidents.

The Performance Contract with LMEs requires that LMEs produce reports and use for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents, and client rights. LMEs must report quarterly all incidents and deaths as well as complaints as part of the Performance Contract with DHHS.

In addition to the above, the Division of Health Service Regulation monitors medication administration for licensed facilities through the licensure process and complaint surveys.

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

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

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

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

Performance Measure:

Proportion of Person Centered Plans that include strategies to address risks identified in the Risk Assessment. N=All Person Centered Plans that include strategies to address risks identified in the Risk Assessment. D= All Person Centered Plans

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMA Monthly PCP Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Break out by MFP, case management agency and LME
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Proportion of Level III incident reports of abuse that were submitted to the host LME and to DMH/DD/SAS within the required time limit.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Proportion of participants who had at least one report of abuse, neglect or exploitation. N=Total number of participants with at least one report of abuse, neglect or exploitation within the year.
D=Total number of participants current year

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
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Performance Measure:

The proportion of participants who reported Level II incidents of verbal, emotional, physical or sexual abuse in the past year.. N=Number of participants reporting each type of abuse in the current year D=Number participants in the current year

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The proportion of participants who reported Level III incidents of verbal, emotional, physical or sexual abuse in the past year. N=Number of participants reporting each type of abuse in the current year D=Total number participants in the current year

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of participants who have planned restraints N=Number of participants with any form of planned restraint, excluding mechanical devices used for body positioning or alignment D= Total number of participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of participants who were restrained 4 or more times per quarter (excluding mechanical devices used for body positioning or alignment N=All participants who were restrained 4 or more times per quarter. D= Total number of participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Data

Responsible Party for data collection/generation(<i>check each</i>	Frequency of data collection/generation(<i>check each</i>	Sampling Approach(<i>check each that applies</i>):

<i>that applies):</i>	<i>that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Total number of Level II and III medication errors reported quarterly and annually.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LME Quarterly Incident Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of surveyed participants who stated they are always/sometimes afraid or scared in their homes and in their neighborhoods. N=Number of surveyed participants who answered always/sometimes to being afraid in their homes and neighborhoods.. D=Total number of surveyed participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of surveyed participants who had a physical examination in the past year. N = All participants who said they have had a physical examination in the past year. D = All participants who were surveyed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of surveyed female participants who had an OB/GYN examination in the past year. N = All female participants who said they had an OB-GYN examination in the past year. D = All female participants who were surveyed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other	
	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Proportion of surveyed participants who had a routine dental visit in the past year. N = All participants who said they have had a routine dental visit in the past year. D = All participants who were surveyed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators Consumer Survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
- a.i.a. 1 The waiver case management monitoring protocol requires the targeted case manager conduct a quarterly face to face meeting with the participant to ascertain if all services in the PCP that address health, safety and welfare are being provided according to the plan. The case management monitoring protocol also requires oversight of the participant’s health, welfare and safety, including any injuries or other unusual incidents that may have occurred. Prior to or during the PCP meeting, the team, along with the participant/guardian, conducts a risk assessment (using a uniform Risk Assessment Tool) which is incorporated into the Crisis Plan, contained in the PCP. The PCP must address the identified risks in order that the participant’s risks may be minimized. The PCP must also contain as a behavioral plan as needed, which may include an approved restrictive intervention plan. The DMH/DD/SAS Best Practice Team reviews and approves all initial PCPs and CNRs for the Money Follows the Person(MFP)participants and for PCPs that are at or above \$100,000. The Utilization Review vendor reviews and approves all initial PCPs and CNRs for all other waiver participants. DMA conducts monthly reviews of approved PCPs. DMA monitors the plan for how the risks noted in the Risk Assessment are addressed.
- a.i.a.2 – a.i.a.9 North Carolina Administrative Code 10A NCAC 12G.0603 requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the DMH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This will include the MFP participants. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of the participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuser neglect or exploitation, and participant behavior issues. Providers are responsible for responding to all incidents and submitting to the LME reports on all Level II incidents (e.g., incidents where police are involved, injuries requiring medical treatment). Providers submit to both the LME and to DMH/DD/SAS reports on all Level III incidents (e.g., incidents that cause permanent injury or death). Providers also report quarterly aggregate information to the LME on a Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid). LMEs are responsible for ensuring that providers submit incident reports as required and respond appropriately to minimize harm from the incident and the likelihood of future incidents. LME’s must report to DMH/DD/SAS quarterly on their analysis and response to trends on all incidents and deaths as part of the Performance Contract with the DHHS. The DMH/DD/SAS Quality Management and CSCR Teams provide oversight and technical assistance to the LMEs to ensure that Level III incidents are fully addressed by providers. The DMH/DD/SAS Quality Management (QM) Team maintains an internal database on reported Level III incidents. From this data and the Quarterly Incident Reports submitted by the LMEs, quarterly and annual trend analysis reports are created and reviewed by the team for comparison on an LME level. The QM Team reviews the reports to identify trends that may need to be responded to by remediation and improvement activities to assure that the underlying philosophy and assurances of the CAP-MR/DD waiver are maintained. The Internal QM Review Committee will also review these reports to identify trends and issues that may need remediation and improvement activities.
- a.i.a.10 ,11, a.i.a.12, a.i.a.13 The DMH/DD/SAS Quality Management Team (QM) conducts National Core Indicators Consumer Surveys annually. Health and Safety data from the National Core Indicators surveys is analyzed by the QM team to

ascertain what proportion of surveyed participants are receiving adequate health monitoring by medical professionals and what proportion of surveyed participants are afraid in their homes and/or neighborhoods.

b. Methods for Remediation/Fixing Individual Problems

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

a.i.a.1 The targeted case manager must ensure that the Person Centered Plan is kept current with the participant’s changing needs. When the targeted case manager discovers that a participant is at risk, s/he must address the issue. This may include any of the following: calling a team meeting to address the issue, securing medical care for the participant, ensuring the participant is removed immediately from the environment that has put him or her at risk. If the targeted case manager discovers that the participant has had multiple incident reports submitted for the same or different incidents, s/he must address this with the team or in whatever manner is necessitated by the severity of the incident. The targeted case manager must ensure that the crisis plan and behavioral plans are updated on a continuous basis as the participant’s needs change.

a.i.a.2 – a.i.a.9 The LME will review all incident reports submitted and follow up with the provider agency on any findings. The LME may conduct an on-site monitoring of the provider if findings indicate this is warranted. The LME works closely with the provider to ensure the health, safety and welfare of the participant involved as well as any others who may be at risk. The LME may require additional information or corrections, technical assistance for the provider and/or staff or may require a plan of correction. If warranted, the LME may withdraw the provider’s endorsement. The LME may at any time remove a participant from the provider premises in order to protect the participant.

In the case of licensed providers, The Division of Health Services Regulation (DHSR) reviews all Level III death reports and may investigate them if warranted. Based on their findings, DHSR may require a plan of correction, which they follow up on, require a plan of correction, fine the provider, revoke the provider’s license or close the provider as warranted.

a.i.a.2 –a.i.a.13 The DMH/DD/SAS QM team will aggregate and review complaint data, incident data, and National Core Indicators data to examine any trends that suggest health and safety vulnerabilities of CAP-MR/DD waiver participants generally and MFP participants specifically. Individual findings and troublesome trends will be reported to the LMEs for action and followed up by the DMH/DD/SAS.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No
- Yes

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

DMH/DD/SAS is developing a web based incident reporting application that will allow providers to report Level II and III incidents on line. This system will track and save all Level II and III incidents in a data base that will provide reports including numbers of each type of incident reported paired as needed with demographic information. The application will be used by the entire DMH/DD/SAS system but it will allow for the breakout of data specific to the MFP participants, the Comprehensive

Waiver participants and the and the Supports Waiver participants. This new application will allow the LME and the Division to better monitor the incident data and more quickly respond to trends or patterns. This application will also automatically send incident reports to the Division of Health Services Regulation Complaint Unit as well as the Health Care Personnel Registry. The new application is anticipated to go live no later than July 1, 2009. The waiver operating agency, DMH/DD/SAS will be responsible for the new application.

DMH/DD/SAS is developing a Risk Assessment Tool to be utilized by the targeted case manager along with other members of the PCP team, including the participant and/or guardian. This tool will be implemented by April 1, 2009.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMA and the DMH/DD/SAS are agencies of the North Carolina Department of Health and Human Services. DMA and DMH/DD/SAS have developed a quality management plan that integrates, analyzes and responds to information from multiple sources across functions within the state system. The plan involves partners and stakeholders including participants/families, provider agencies, Local Management Entity representatives and representatives from various agencies of the State system. The Interagency Waiver Team (IWT) is comprised of staff from DMA DMH/DD/SAS and the state contracted Utilization Vendor. It performs and oversees the day-to-day operation of the waivers. The responsibilities of the IWT include: Provide training and technical assistance to the waiver community as needed; Analyze trended data and take action to remediate findings; Review and prioritize recommendations from all stakeholders and make changes as deemed appropriate; Disseminate information compiled from analysis of QA/QI data to appropriate stakeholders, including participants, family members and system advocates. NOTE: All recommended changes to the waivers must flow through the IWT. A QI/QA committee will be comprised of members of the DMH/DD/SAS Quality Management Team, members of other DMH/DD/SAS teams as well as members of the IWT. This Internal Quality Management Committee (IQMC) will be convened monthly. This committee will work to support and encourage systematic quality management activities and consistent expectations for all MH/DD/SAS participants, including the Money Follows the Person participants. The responsibilities of the IQMC include: Reviewing QA/QI system data received from the responsible entities/agencies. The IQMC shall review the data at a minimum quarterly. Meetings shall be scheduled 1X per calendar quarter. Meeting minutes shall be kept at all workgroup meetings; Analyzing data to determine patterns, trends, problems, and issues relative to all assurances; Making recommendations to the IWT for changes in policies and procedures based on analysis of compiled QA/QI data; Making recommendations to the IWT regarding the provision of training, technical assistance and other activities, based on analysis of QA/QI data and conducting follow-up monitoring of the activity to assure remediation and statewideness; continuing to develop and refine the QA/QI quality indicators to be monitored; Reviewing the QA/QI plan at least annually and making changes as needed to assure that the data gathered is generating useful information to improve quality of service delivery; Reviewing the QA/QI policies and procedures at least annually and modifying as needed; Disseminating information compiled from analysis of QA/QI data to stakeholders, including participants, families and system advocates. In addition to these activities, each QM performance indicator written into the waiver includes the type and frequency of activity in gathering data specific to the indicator, the sampling methods for each indicator, how data will be collected, who will collect the data. Data gathered during the first waiver year will be used to establish baseline performance levels and will be the basis for setting acceptable thresholds for each indicator for the following waiver years. Through the analysis and review process indicators that reflect changes from expected trends will be identified for further analysis and study. If applicable, special studies will be undertaken on prioritized measures to understand changes in trends. The Participants and their families will: Contact their case managers if they have concerns about their services or supports; Access grievance and complaint processes, with assistance from their case managers, if needed, based on materials provided by the LME; Provide feedback on state and local plans and budgets; Help identify under-served populations and gaps in the service array; Participate in the monitoring of service development and delivery through participation in surveys and stakeholders meetings; Review reports generated by DMH/DD/SAS; Advise on the development of additional services and new models of service delivery; Participate in quality improvement projects at the provider and LME level. NOTE: Participants and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). LME(s) have established committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACs). The local CFAC(s) are a self-governing and a self-directed organization that advises the LME(s) in its catchment area on the planning and management of the local public mental health, developmental disabilities, and substance abuse services system.

Case managers are responsible for:

Facilitating the Person Centered Planning (PCP) process and ensuring that the PCP includes all needed services and supports as well as all state and waiver requirements (including a Crisis Plan based on a risk assessment); Reassessing each participant's needs at least annually and developing a revised PCP based on that reassessment (Continued Need Review); Acting on and remediating any issues related to the participant's health, safety, and welfare or service delivery. Unresolved issues will be brought to the attention of the LME; Revising the PCP as the participant's needs change; Conducting quarterly face-to-face visits with the participant to: Oversee PCP implementation; monitor health safety and welfare; identify risk factors determine if the back up plan remains effective and is implemented as written. NOTE: Monitoring will be facilitated and made consistent statewide (except for the Piedmont LME catchment area) through use of a uniform monitoring tool.

Other waiver service provider agencies are responsible for:

Maintaining licensure, certification and accreditation as required, including ensuring that staff are qualified to deliver services and staff receive required supervision; Monitoring the provision of services; contacting the case manager if there are any concerns regarding the participant; Participating in the development of the PCP; Implementing the PCP including risk mitigation strategies and the back-up plan; Submitting Incident Reports and Quarterly Incident Reports as required by DHHS rules; Responding appropriately to all

participant incidents; maintaining documentation of Level I incidents in-house; Reporting and remediating Level II incidents to the LME; reporting Level III incidents to the LME and DMH/DD/SAS; Reporting quarterly Level I incident aggregate data (and other required data) to the LME (Quarterly Provider Incident Report); Developing and implementing an internal quality improvement plan; Developing and convening an internal client rights committee; Participating in stakeholders' meetings. The Utilization Review Vendor is responsible for: Reviewing and approving plans; contacting the case manager to address any findings of incomplete plans prior to approval; ensuring that case managers have corrected any identified deficiencies prior to approval and approving services in line with service requirements and criteria.

The Local Management Entities (LMEs) are the local lead agencies for the counties they serve and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

Developing a community of qualified providers; operating a uniform local access system; Conducting and overseeing the provider endorsement process for providers; Monitoring, evaluating and conducting continuous quality improvement; Managing secure information systems with data on participants, providers services and finances; Monitoring and overseeing services, including provider compliance with standards for state and waiver requirements, provider qualifications, and utilization; Providing technical assistance to providers; Providing information to waiver participants including their responsibilities, protections and rights, as well as grievance and complaint resolution processes; Resolving issues related to any participant's health, safety, welfare or service delivery that are unresolved by the case manager; Investigating complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rules; Ensuring that MH/DD/SAS providers participate in the DHHS incident reporting system; Receiving, reviewing and following up on incident reports from MH/DD/SAS providers as required by DHHS rules; Ensuring that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that a participant may be abused, neglected or exploited; Submitting the Quarterly LME Incident Report and Quarterly Complaint Report to DMH/DD/SAS and to the local Client Rights Committee; Submitting a Quarterly Provider Monitoring Report of monthly local monitoring activities to the Division of Health Services Regulation and DMH/DD/SAS that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues; Providing on-call emergency back-up through the LME to provide staff in the event that the emergency back-up strategies identified in the Person Centered Plan cannot be implemented and there is potential that the participant's health safety or welfare could be jeopardized.

DMH/DD/SAS has primary responsibility for implementation and oversight of the waiver. These responsibilities include: Monitoring CAP-MR/DD providers, including yearly audits of paid claims to CAP-MR/DD providers, as well as record reviews and PCP reviews; Investigating incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services. Incidents and complaints regarding licensed facilities are investigated by or jointly with the Division of Health Services Regulation; Tracking, reviewing, analyzing and reporting on aggregated data reported on all waiver assurances; Tracking and reviewing incident reports and investigating as needed; Collecting, aggregating, analyzing and reporting quarterly and annually on statewide and sub-state incident and complaint data; Developing expectations through the promulgation of performance contracts with LMEs; Routinely monitoring the performance of LMEs; Conducting yearly accountability audits of the LMEs and providers; this audit will include a targeted review of all participants in MFP using a standardized review instrument; Conducting surveys of individual and family outcomes; Conducting reviews of high cost PCPs (over \$100,000) and all PCPs of individuals participating in the Money Follows the Person, regardless of cost; Assisting in the identification of individuals choosing the option to return to community living through implementation of a standardized Community Options Interest Survey; Meeting with DMA on at least a quarterly basis to review trends and issues and to communicate information on any needed changes to the waiver.

DMA will: Conduct monthly audits of a sample of Level Of Care and PCPs for waiver participants; Conduct fiscal audits of the waiver programs; Review waiver data/evidence from DMH/DD/SAS; Ensure remediation by DMH/DD/SAS for any identified issues and conduct ad hoc reviews of the waiver program; Meet with DMH/DD/SAS on at least a quarterly basis to review trends and issues and to communicate information on any new CMS policies and procedures; Enroll qualified providers; Oversee the performance of the Utilization Review vendor.

DMH/DD/SAS and DMA together are responsible for: Overseeing contracts with Local Management Entities (LME); Setting performance standards for LMEs and providers; Monitoring regulatory compliance with state, federal, and waiver requirements.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually

Other

Specify:
UR vendor and Case Management agencies

Other

Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

No system design changes are planned to occur prior the end of the first waiver year. After the first year of waiver implementation, using the reports based on the performance indicators data, as well as trend analysis of the various reports, observations by the IWT, participants, families and service providers, the IQMC will recommend targets for quality and uniform services as well as address remediation strategies as needed. There will be alerts set as points of measure ascertaining when things are going right or wrong (benchmarks). These benchmarks will be monitored quarterly and adjusted as needed. Unless they have been revised or replaced, the original performance indicators will remain in use and the year-one data will serve as baselines for future comparison and analysis. The IQMC will recommend Quality Management System (QMS) changes to the IWT. The IWT will prioritize and implement the changes.

This process may be amended over time, perhaps in the first waiver year, as the IQMC develops its internal processes.

Changes to the QMS that will affect the QM process for any team, provider agency or LME will be formally communicated jointly by the DMH/DD/SAS and DMA, which is published on the internet and is available to the public. Some changes may be communicated to various stakeholders via letters or memos.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality management strategy for the waiver includes identification of defined performance measures that are developed by the IQMC and approved by the IWT. Performance measures are calculated and present by LME, county, and provider agency (where appropriate) and address topics such as:

- Service availability and consumer choice of providers
- Service access – treated prevalence rates, timeliness and appropriateness
- Consumer and family involvement in service/supports planning and delivery
- Consumer quality of life (e.g. health, safety, living arrangements, control over decisions, daily activities, community inclusion)

As outlined in H.1.a.i each level of the system has responsibilities for collecting, analyzing and using data to manage and improve the quality of waiver services. These data provide information for the performance measures. In addition, these data are used to evaluate the service system and identify areas in need of improvement. Most of the data are collected by case managers, providers, LMEs, and the UR vendor. These data are moved upward in the system to DMA and DMH/DD/SAS for analysis, reporting, dissemination, and review. Major topics that are formally reported and reviewed include summaries of trends and patterns in:

- Restrictive interventions, consumer incidents and deaths and remediation actions
- Complaints and violations of consumer rights and remediation actions
- Provider enrollments, monitoring & audit activities, infractions, and disenrollments
- Service access timeliness
- Service utilization (costs and intensity) by levels of service/support needs
- Consumers' quality of life and perceptions of care

Analyses of these topics provide information that is disseminated in a variety of ways to a variety of audiences. The types of reports include:

- Detailed technical reports are provided to LMEs responsible for oversight of the local service system. These reports are often provided in formats, such as MS Excel workbooks, that allow additional analysis by analytic staff.
- Brief reports are provided to state and local leadership and in the form of monthly graphs or bulleted highlights to allow decision makers to monitor progress and performance on a variety of topics.
- Graphical reports are published quarterly that compare LMEs on formal performance measures. These reports are disseminated to all stakeholders.
- “Data briefs” are published periodically to inform stakeholders and the public about findings on a particular topic.

Most reports are published on the DMA and DMH/DD/SAS websites and disseminated to local stakeholders by email. Printed copies of reports directed to consumers, families and the public are also printed and given to LMEs for distribution.

Evaluation of the QM strategy will be accomplished through self-accountability, oversight by the DMH/DD/SAS Executive Leadership team and through communication to and feedback from key stakeholders.

The IQMC will evaluate itself in achieving both the process and outcome goals. The IQMC will assess the success of the processes undertaken for the monitoring of the system. The process measures will include but not be limited to frequency of the meeting, the ability of the committee to meet targets of the work plan, and timely review and mitigation of relevant measures. The IQMC members will convene quarterly to identify areas of concern within their own functioning. The outcome of interest would be the ability of the strategy to fulfill the quality management mandate for the waiver.

The DMH/DD/SAS Executive Leadership Team will periodically review the status of the performance measures and the corrective processes undertaken by the IQMC.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The North Carolina General Assembly, in session law 2001-437, designated the local mental health authorities as the “locus of coordination” for the provision of all publicly funded MH/DD/SAS services. The local mental health authorities are known as Local Management Entities (LME). LMEs are the local lead agencies for the day to day operations of the waiver in the counties they serve. LMEs assure that the policies and procedures for all programs in the public MH/DD/SAS services system are followed, including waiver services. They are responsible for the health, safety and welfare of individuals receiving services, for assuring integrity of the provision of services and supports with the service plan/Person Centered Plan, and for assuring that individuals receive the appropriate level of care. DMH/DD/SAS is responsible to manage slot allocations and working with the LME's are to ensure appropriate and accurate use of Waiver funds. The providers bill Medicaid directly for reimbursement of waiver services provided. Reimbursement for waiver services is paid directly to service providers by the Medicaid agency upon the submission of clean billing claims. This assures that payment is made in a timely manner.

DMH/DD/SAS and DMA jointly ensure that the actual total expenditure for home and community based and other Medicaid services under the waiver and the claim for FFP in expenditures for the services provided to individuals under the waiver do not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the ICF-MR institutional settings.

The Budget and Finance Team also develops a monthly report that describes the services paid for waiver recipients, the number of units billed, the cost and the number of consumers receiving each service. This data provides the ability to view services paid per individual consumer, as well as per individual LME or provider. This data may be used in the event that there is a concern or complaint received regarding a specific consumer or provider.

Medicaid Compliance Audits

The DMH/DD/SAS Accountability Team and DMA's Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events per a sample of individual directly enrolled providers. This review includes monitoring of both DMA/waiver and DMH requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. These reviews assure that documentation and other requirements were followed for services that providers billed to Medicaid and for which they were paid.

DMA Program Integrity Reviews

DMA Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarification.

The Medicaid Compliance Audit is conducted using an audit tool created and revised by the DMH/DD/SAS and DMA. Regular analysis of audit results allows for revision to the tools based on areas of concern that reflect compliance with Medicaid documentation requirements, adherence to the service definitions and with the requirements for qualifications and training of service providers. The annual sample of agencies to be audited takes into consideration compliance from previous years, so that providers with extensive systemic issues will be audited more frequently than those with good to excellent compliance ratios. If a provider has 90% compliance

or better, it is excluded from the next year's sample. If a provider has 50% compliance or worse, it is automatically included the next year. There are instances when this protocol may not be followed if a targeted sample is requested by DHHS (for example the review of plans with budgets of \$100,000 or more).

DMA Program Integrity Reviews are initiated based on information received from a variety of sources, including:

- Recipients or family members' complaints
- Reports or complaints from other provider agencies, other state agencies, county agencies or other DMA sections
- Patterns of practice and use of services identified in Quarterly Surveillance and Utilization Review Subsystem reports of the Medicaid Management Information System that fall outside of the norm for provider agencies and recipient peer groups.
- Special computer runs based on reports from referrals to look at specific issues, procedure codes, and possible duplication of services that identify a need for review.
- Identification of a problem with one provider agency that indicates a need to review other provider agencies of the same service in regard to the same potential problem.
- Random sample reviews
- Areas that the agency under contract with DMA to process Medicaid claims identifies as questionable during claims processing.

Providers are subject to payback for events found not in compliance during audits, and/or they are subject to written plans of correction for out of compliance issues that are systemic in nature. Submission and determination of paybacks, self-assessments for items requiring more than a single event payback, adjustments and/or recoupment goes through DMA Program Integrity and the Controller's Office. Requests for reconsideration (appeal) also go through DMA Program Integrity and The DMA Hearing Office. Plans of Correction are handled by DMH/DD/SAS, and if required, must be approved by DMH/DD/SAS with follow up to determine the plan has been implemented occurring within 90 days of the approval date. If a plan of correction is not submitted or not implemented within the identified timeframe, action could follow resulting in termination of the ability to provide services using public monies. Results of the audits are published on the DMH/DD/SAS website.

Program Integrity cooperates with the State Medicaid Investigations unit of the Attorney General's office and the staff of county Departments of Social Services to identify and investigate instances of fraud and abuse. If the discovery process reveals fraud, and referral is made to the Fraud Unit of the Department of Justice. Recoupment of funds or revocation of provider enrollment number may result.

Providers of CAP-MR/DD Medicaid services are additionally subject to the Division of Medical Assistance's financial audits. Providers are required to submit cost reports at DMA's request and are subject to 22J NCAC as well as 22F which govern the Program Integrity Reviews stated above.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

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

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

Performance Measure:

DMA requires providers enrolled to provide CAP-MR/DD services to submit an annual cost report. If this report is not submitted and completed in accord with filing guidelines, they may be subject to a 20% payment withhold.

Data Source (Select one):
 Financial records (including expenditures)
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 Post-Payment reviews by DMA/DMH will look at the complete audit trail.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Utilization Review Vendor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Utilization Review Vendor	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

DMA will compare authorized services against actual claims data.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: Local Management Entities and Case Managers	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As needed

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. By conducting post payment reviews, DHHS is able to look at the complete financial integrity of the payment process. A detailed approach looks at the plan approval against the utilization review to authorize services approved on the plan to the provider, the provider's provision of services along with documentation against actual claims data.

b. Methods for Remediation/Fixing Individual Problems

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

Post payment reviews conducted by DMA and DMH look at the complete audit trail. The approval of the plan, the utilization review vendor authorization to the provider to render approved services, service provision, service documentation and actual claims data.

ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

c. Timelines

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

- No
- Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DMH/DD/SAS and DMA have developed a standardized process to ensure that rates for all mental health, developmental disabilities and substance abuse services rates are adequate and appropriate:

1. Provider costs are modeled including factors such as wage rates and fringe benefits; net billable hours after accounting for sick, vacation and holiday leave; and administrative overhead expenses.
2. Proposed reimbursement rates are produced for each service based on the staffing requirements identified through the process noted above.
3. The DMH/DD/SAS issues an invitation for all providers to register with DMH/DD/SAS to indicate their interest in participating in policy forums related to mental health, developmental disabilities, and substance abuse services issues.
4. Providers are required to submit cost data specific to their agencies.
5. Providers are required to submit a cost summary annually in accord with DMA filing guidelines and if noncompliant, may be subject to a 20% withhold.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

If a participant of the Supports waiver chooses an enrolled provider for service provision, the enrolled provider will submit claims for payment directly to the State's claims payment system.

Individuals who choose to direct their own services and supports must enter into a working arrangement with a Financial Management Provider, who will pay the participant's staff, and handle federal/state taxes and other payroll or benefits related to employment of the support person. The Financial Management Provider (FM) may submit claims on behalf of a participant for payment directly to the State's claims payment system for those services provided through an Individual Provider selected by the participant. If billing Medicaid services on behalf of participants, the Financial Management provider must enroll with the Division of Medical Assistance, sign a provider Participation Agreement, and receive a provider ID number. Subcontractors are subject to all rules and regulations, which govern Medicaid reviews/audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present.
Completed claims processed through MMIS are run against system edits and audits to verify:
Services are prior authorized (i.e., level of care);
Recipient is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator)
Provider is an enrolled waiver provider;
Claim is paid per the published rates;
Claim is not a duplicate; and
Participant was not institutionalized during the time covered.

Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits and audits to ensure that only valid claims for eligible clients and covered services are reimbursed to enrolled providers.

Validation that services have been provided as billed is a function of quality assurance conducted by the DMA/DMH. Audits include verification that the services were provided as billed. Additional validation that services were provided as billed is performed during lead agency and provider on-site compliance monitoring reviews conducted by DMA.

The DMH/DD/SAS and DMA are responsible for:

• **Medicaid Compliance Audits**

The DMH/DD/SAS Accountability Team and DMA's Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events per a sample of individual directly enrolled providers. This review includes monitoring of both DMA/waiver and DMH/DD/SAS requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. These reviews assure that documentation and other

requirements were followed for services that providers billed to Medicaid and for which they were paid.

DMA Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarification.

The Medicaid Compliance Audit is conducted using an audit tool created and revised by the DMH/DD/SAS and DMA. Regular analysis of audit results allows for revision to the tools based on areas of concern that reflect both financial accountability and quality treatment or services. The annual sample of agencies to be audited takes into consideration compliance from previous years, so that providers with extensive systemic issues will be audited more frequently than those with good to excellent compliance ratios. If a provider has 90% compliance or better it is excluded from the next year's sample. If a provider has 50% compliance or worse, it is automatically included the next year.

DMA Program Integrity Reviews are initiated based on information received from a variety of sources, including:

- Recipients or family members' complaints
- Reports or complaints from other provider agencies, other state agencies, county agencies or other DMA sections
- Patterns of practice and use of services identified in Quarterly Surveillance and Utilization Review Subsystem reports of the Medicaid Management Information System that fall outside of the norm for provider agencies and recipient peer groups.
- Special computer runs based on reports from referrals to look at specific issues, procedure codes, and possible duplication of services that identify a need for review.
- Identification of a problem with one provider agency that indicates a need to review other provider agencies of the same service in regard to the same potential problem.
- Random sample reviews
- Areas that the agency under contract with DMA to process Medicaid claims identifies as questionable during claims processing.

Providers are subject to payback for events found not in compliance during audits, and/or they are subject to written plans of correction for out of compliance issues that are systemic in nature. Submission and determination of paybacks, self-assessments for items requiring more than a single event payback, adjustments and/or recoupment goes through DMA Program Integrity and the Controller's Office. Requests for reconsideration (appeal) also go through DMA Program Integrity and The DMA Hearing Office. Plans of Correction are handled by DMH/DD/SAS, and if required, must be approved by DMH/DD/SAS with follow up to determine the plan has been implemented occurring within 90 days of the approval date. If a plan of correction is not submitted or not implemented within the identified timeframe, action could follow resulting in termination of the ability to provide services using public monies. Results of the audits are published on the DMH/DD/SAS website.

Program Integrity cooperates with the State Medicaid Investigations unit of the Attorney General and the staff of county Departments of Social Services to identify and investigate instances of fraud and abuse. If the discover process reveals fraud, and referral is made to the Fraud Unit of the Department of Justice. Recoupment of funds or revocation of provider enrollment number may result.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Local Management Entities are eligible to receive payment for waiver services. Public and private providers are paid the same.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Governmental providers receive the same interim payment amount as private providers. Annually, the governmental provider reports its cost using a cost report. Any excess payment above actual allowed waiver cost is recouped and the excess payment is returned to CMS on the quarterly expenditures report.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

County Boards of Commissioners have the authority to levy ad valorem taxes.

Currently counties partner with the state in the non-federal share of waiver services.

The DHHS collects these funds with electronic site drafts drawn from each county's designated account.

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Non applicable

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

No service codes applicable to bill for CAP-MR/DD services are inclusive of Room and Board.

On the cost reports submitted by CAP-MR/DD enrolled providers, room and board expenses are excluded.

Room and Board is not an allowable cost item on the cost report.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

- ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

- iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8579.50	5601.63	14181.13	117554.84	4066.59	121621.43	107440.30
2	10296.89	6413.57	16710.46	122021.92	4221.12	126243.04	109532.58
3	11373.04	7040.61	18413.65	126658.75	4381.52	131040.27	112626.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/MR	
Year 1	2000		2000
Year 2	3000		

			3000
Year 3	4000		4000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Based on Medicaid claims payments for current CAPMR/DD waiver services provided in calendar years 2006, 2007, and year-to-date 2008 (we have data on claims paid through June 2008) and on information concerning persons in the process of entering the waiver, we estimate that there will be approximately 950 persons who will move from the current CAPMR/DD waiver to the new Supports waiver as of November 1, 2008. Our experience with the current waiver indicates slightly over 3% of persons who receive waiver services in a given year will leave the waiver in that year. We assume that this same rate will apply in the new waiver. For years 2 and 3 of the new waiver, we assume that 100 persons from the Supports waiver will transfer to the Comprehensive waiver on November 1, the beginning of the waiver year. New persons will be added to the waiver throughout each year to bring the total served in a year to the allowed numbers. We are assuming that persons who exit and enter the waiver, excepting the transfer from the Supports waiver, will do so uniformly throughout the waiver year, so that on average such persons are on the waiver for half a year, as compared to those who begin and end the year on the waiver who are there for a full year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The starting point for these estimates are claims paid for existing waiver services provided in calendar year 2007, based on payments made through June, 2008. We did not apply an adjustment for claims for cy2007 service that might be paid after June, 2008 because an examination of cy2006 waiver service showed that average dollars per person increased by only 0.04% comparing claims paid through June 2008 to those paid through June 2007. Claims data originated in the state's MMIS system and included adjustments that were service specific. Based on an examination of service provided in cy2006, cy2007, and available year-to-date billings for cy2008, we partitioned all persons who received waiver services in cy2007 into two groups. The low cost group appeared likely to track to the Supports waiver, with a maximum annual expenditure for waiver services of \$17,500. The utilization history in cy2007 for this group was the base data used for the estimates for factor D for the Supports waiver. The cy2007 service utilization data for the remaining persons in the CAPMR/DD waiver constitute the base data used for the estimates for factor D for the Comprehensive waiver. Thus, we begin with actual utilization data from the current CAPMR/DD waiver for clients who appear, based on claims history, to map to the Supports waiver. (Note: a person might have mapped to the Comprehensive waiver even though their total cost for cy2007 waiver services was less than \$17,500. For example, consider someone who entered the waiver in July 2007 and had cy2007 expenditures of \$12,000. As we would expect their expenditures for a full year on the waiver to be closer to \$24,000, their utilization data would have been mapped to the Comprehensive waiver rather than the Supports waiver.) For cy2007, we calculated the number of observed users for each service, their estimated average units per user, and the observed average cost per unit.

All of the services provided under the old waiver continue in the new Supports waiver, with the exception of Residential Supports. However, because of the cap on annual expenditures for waiver services, persons receiving Residential Supports mapped to the Comprehensive waiver, not the Supports waiver. In addition, the new Supports waiver adds four new services, two of which have multiple components: behavioral consultant, crisis respite, long term vocational supports and individual goods and services.

To estimate utilization of services, we assumed that persons on the Supports waiver could be considered as part of two populations, each with a potentially different pattern of service utilization. One group would look much like the persons identified as low cost in the existing waiver. The other would be persons who would have utilized at a higher rate had they entered the Comprehensive waiver, but who choose to enter the Supports waiver in lieu of waiting for an available slot in the

Comprehensive waiver. All persons transitioning from the old waiver to the Supports waiver were considered to be in the first group. DMH/DD/SAS professional staff used their professional judgment to estimate the percentage of clients added to the Support waiver each year who would fall in the two groups.

Starting with the observed pattern of service utilization from cy2007, DMH/DD/SAS professional staff used their professional judgment to estimate the expected number of users and units per user for the new waiver services, as well as any offsetting reductions in the utilization of old service that would result. They also considered any utilization changes to be expected due to any changes in existing service definitions. We adjusted the estimates of units per person to account for any differences in the estimated ALOS in the waiver years as compared to the estimated ALOS in cy2007 for the clients in the low utilization group. We then adjusted the estimated number of users per service to account for the difference in total number of persons each new waiver year compared to the number in the base period. This process was repeated for both populations entering the Supports waiver.

To estimate average cost per unit in the new waiver years, we started with the observed cost per unit for the existing waiver services in cy2007. Not surprisingly, these were very close to although slightly lower than the maximum allowed rate per unit. We did adjust for two minor rate changes (increases of \$0.02 per unit) that would not have appeared in the cy2007 data. (Note, for one service, Day Supports individual, the observed cost per unit in cy2007 for the low cost group was significantly below both the allowed maximum rate and the observed average rate for the high cost group. There were also only 38 persons in the low cost group who receive this service. We substituted the observed average cost per unit from the high cost group in this instance.) The State has contracted with Mercer to determine rates for the new services; although this process is not complete, we have used their preliminary rates for these services for waiver year 1.

For individual goods and services, which will only be available to those choosing to self direct in waiver years 2 and 3, staff estimated that an average client would bill 7 times in a year for a total of \$3000, provided they were self-directing for the entire year. We then estimated the average units per user and observed rate, given that not all persons would self direct for an entire waiver year.

We do not anticipate immediate rate changes for any of the existing services, so we did not change the observed cost per unit from the observed cy2007 levels. For years 2 and 3, we applied an inflation adjustment of 3.8% per year, based on the professional medical component of the CPI-U for June 2008.

Lastly, we added the estimated users per unit, projected dollars, and projected units from the two populations entering the Supports waiver. By dividing total projected dollars by total projected units we estimated the average cost per unit for the entire Supports waiver. Likewise, by dividing total projected units by total persons, we estimated the number of units per user for the total Supports waiver.

Change for Sept. 9, 2008: We have dropped Behavioral Consultant Level I.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For the same group of lower cost CAPMR/DD waiver recipients whose cy2007 waiver service utilization data became the base data for factor D, we collected all additional Medicaid service expenditures for cy2007 service, restricted to the period they were in the waiver. As total non-waiver service Medicaid dollars for service provided in cy2006 for persons on the current CAPMR/DD increased by 1.5% when comparing claims paid through June 2008 to those paid through June 2007, we have increased the cy2007 dollars by 1.5% to account for the claims for cy2007 service that will be paid after June 2008. Again, the source was the state MMIS, based on claims paid through June 2008. We used these costs to estimate the non-waiver service costs for those persons entering the Supports waiver who would have similar utilization profiles. For the group of persons entering the Supports waiver who might otherwise have waited to enter the Comprehensive waiver, we have used the non-waiver service costs for those higher cost persons whose costs mapped to the Comprehensive waiver, which are slightly higher. To go from the cy2007 base data to the estimates by waiver year for each group, we adjusted average dollars per person per year to account for differences in ALOS and inflation. Once again, we used an inflation factor from the June 2008 CPI-U of 3.8% per year, but in this case we applied it to all months from the base year, 2007, to the waiver years. We then calculated a weighted average of the average cost per person in each group, with the weights being the percentage of persons in each group, to obtain the overall results for the Supports waiver.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

As the applicable Level of Care is ICF/MR, we based our estimate for Factor G on the observed Medicaid cost per client in ICFMRs, both community based and state run. Base data was derived from the state MMIS based on claims paid through April 2008 for service provided in calendar year 2007. An examination of similar claims for cy2006 showed that only 0.14% more dollars were paid in the 12 months following April 2007, so we did not add an adjustment for cy2007 service that had not yet been paid. We excluded costs for persons on the CAPMR/DD waiver who received service in an ICFMR and then returned

to the waiver, although this made little difference (cost per person increased by 0.15%.) We then used the same inflation factor as in D and D', 3.8%, to adjust cost per person from cy2007 to waiver years 1, 2 and 3. (Assuming waiver starts November 1, 2008.) Note that the inflation factor is the professional subtotal of the Medical component of the CPI-U for June 2008. The rate for the overall Medical component was 4.0%.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

As the applicable Level of Care is ICF/MR, we based our estimate for Factor G' on the observed cost per client for all other Medicaid services for persons in ICFMRs, both community based and state run, in cy2007, limited to the period of time they were in an ICFMR. Base data was derived from the state MMIS based on claims paid through April 2008 for service provided in calendar year 2007. An examination of similar claims for cy2006 showed that 0.56% more dollars were paid in the 12 months following April 2007, so we applied this adjustment for cy2007 service that had not yet been paid. We excluded costs for persons on the CAPMR/DD waiver who received service in an ICFMR and then returned to the waiver. We then used the same inflation factor as in D and D', 3.8%, to adjust cost per person from cy2007 to waiver years 1, 2 and 3. (Assuming waiver starts November 1, 2008.) Note that the inflation factor is the professional subtotal of the Medical component of the CPI-U for June 2008. The rate for the overall Medical component was 4.0%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Individual Goods and Services (self direction only)
Vehicle Adaptation
Day Supports
Adult Day Health
Behavior Consultation Service
Transportation
Specialized Consultative Services
Crisis Services
Supported Employment
PERS (Personal Emergency Response System)
Long Term Vocational Supports
Home and Community Supports
Specialized Equipment and Supplies
Home Modifications
Crisis Respite
Personal Care
Augmentative Communication Devices
Respite
Individual and Caregiver Training

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and

populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services (self direction only) Total:						0.00
Individual Goods and Services (self direction only)	event	0	0.00	429.55	0.00	
Vehicle Adaptation Total:						90109.46
Vehicle Adaptation	event	21	1.09	3936.63	90109.46	
Day Supports Total:						1390317.35
Day Supports Individual	15 minute	103	1331.69	6.15	843559.03	
Day Supports Group (2 or more clients)	15 minute	96	1556.12	3.66	546758.32	
Adult Day Health Total:						172010.11
Adult Day Health	Day	28	154.78	39.69	172010.11	
Behavior Consultation Service Total:						90808.06
behavior consultant - Level 2	15 minute	63	63.53	19.64	78606.94	
behavior consultant - Level 3	15 minute	10	45.80	26.64	12201.12	
Transportation Total:						11625.19
Transportation	event	15	11.25	68.89	11625.19	
Specialized Consultative Services Total:						7667.72
Specialized Consultative Services	15 minute	14	36.08	15.18	7667.72	
Crisis Services Total:						8361.78
Crisis Services	15 minute	6	231.50	6.02	8361.78	
Supported Employment Total:						153372.03
Supported Employment – Individual	15 minute	53	312.32	7.69	127292.26	
Supported Employment – Group	15 minute	40	329.29	1.98	26079.77	
PERS (Personal Emergency Response System) Total:						3978.00
PERS (Personal Emergency Response System)	month	17	8.00	29.25	3978.00	
Long Term Vocational Supports Total:						59042.41
long term vocational supports - individual	15 minute	27	305.84	7.15	59042.41	
long term vocational supports - group	15 minute	0	0.00	1.84	0.00	
Home and Community Supports Total:						11485211.27
Home and Community Supports – Individual	15 minute	1677	1193.21	5.63	11265704.15	
Home and Community Supports – Group (2 or					219507.12	

more clients)	15 minute	80	871.06	3.15		
Specialized Equipment and Supplies Total:						195913.32
Specialized Equipment and Supplies	event	189	48.62	21.32	195913.32	
Home Modifications Total:						65062.80
Home Modifications	event	24	1.00	2710.95	65062.80	
Crisis Respite Total:						14113.44
Crisis Respite	Day	11	4.95	259.20	14113.44	
Personal Care Total:						2148619.27
Personal Care Services	15 minute	730	750.22	3.65	1998961.19	
Enhanced Personal Care Services	15 minute	36	833.10	4.99	149658.08	
Augmentative Communication Devices Total:						43339.78
Augmentative Communication Device - Purchase	event	33	1.34	953.73	42173.94	
Augmentative Communication Device – Repair and Service	event	2	1.52	383.50	1165.84	
Respite Total:						1192035.41
Respite Institutional	Day	0	0.00	222.96	0.00	
Respite Non-Institutional – Individual	15 minute	983	282.99	3.64	1012572.18	
Respite Non-Institutional – Group (2-3 clients)	15 minute	43	638.54	2.82	77429.36	
Enhanced Respite Care – Non Institutional	15 minute	34	285.15	4.97	48184.65	
Respite Nursing – RN	15 minute	10	407.05	9.24	37611.42	
Respite Nursing – LPN	15 minute	8	241.06	8.42	16237.80	
Individual and Caregiver Training Total:						27415.21
Individual and Caregiver Training	15 minute	88	35.85	8.69	27415.21	
GRAND TOTAL:						17159002.61
Total Estimated Unduplicated Participants:						2000
Factor D (Divide total by number of participants):						8579.50
Average Length of Stay on the Waiver:						263

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields

in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services (self direction only) Total:						124999.05
Individual Goods and Services (self direction only)	event	50	5.82	429.55	124999.05	
Vehicle Adaptation Total:						156910.08
Vehicle Adaptation	event	32	1.20	4086.20	156910.08	
Day Supports Total:						2756499.10
Day Supports Individual	15 minute	163	1728.55	6.38	1797588.29	
Day Supports Group (2 or more clients)	15 minute	145	1740.31	3.80	958910.81	
Adult Day Health Total:						299790.15
Adult Day Health	Day	43	169.22	41.20	299790.15	
Behavior Consultation Service Total:						182845.45
behavior consultant - Level 2	15 minute	99	80.43	20.39	162356.80	
behavior consultant - Level 3	15 minute	15	49.40	27.65	20488.65	
Transportation Total:						18543.52
Transportation	event	21	12.35	71.50	18543.52	
Specialized Consultative Services Total:						14215.52
Specialized Consultative Services	15 minute	22	41.00	15.76	14215.52	
Crisis Services Total:						19064.38
Crisis Services	15 minute	10	305.03	6.25	19064.38	
Supported Employment Total:						252337.99
Supported Employment – Individual	15 minute	78	334.09	7.98	207950.98	
Supported Employment – Group	15 minute	60	360.87	2.05	44387.01	
PERS (Personal Emergency Response System) Total:						6094.77
PERS (Personal Emergency Response System)	month	25	8.03	30.36	6094.77	
Long Term Vocational Supports Total:						107243.63
long term vocational supports - individual	15 minute	41	352.52	7.42	107243.63	
long term vocational supports - group	15 minute	0	0.00	1.91	0.00	
Home and Community Supports Total:						19896145.31
Home and Community Supports – Individual	15 minute	2515	1327.07	5.85	19524849.14	
Home and Community Supports – Group (2 or more clients)	15 minute	119	954.17	3.27	371296.17	

Specialized Equipment and Supplies Total:						334357.74
Specialized Equipment and Supplies	event	284	53.20	22.13	334357.74	
Home Modifications Total:						104116.89
Home Modifications	event	37	1.00	2813.97	104116.89	
Crisis Respite Total:						27764.30
Crisis Respite	Day	17	6.07	269.06	27764.30	
Personal Care Total:						4175665.10
Personal Care Services	15 minute	1101	909.50	3.79	3795152.50	
Enhanced Personal Care Services	15 minute	61	1204.23	5.18	380512.60	
Augmentative Communication Devices Total:						75956.02
Augmentative Communication Device - Purchase	event	49	1.47	1024.49	73794.01	
Augmentative Communication Device – Repair and Service	event	3	1.81	398.16	2162.01	
Respite Total:						2259066.40
Respite Institutional	Day	0	0.00	231.43	0.00	
Respite Non-Institutional – Individual	15 minute	1487	336.15	3.78	1889452.09	
Respite Non-Institutional – Group (2-3 clients)	15 minute	64	699.15	2.92	130657.15	
Enhanced Respite Care – Non Institutional	15 minute	59	412.18	5.16	125484.08	
Respite Nursing – RN	15 minute	17	473.95	9.59	77268.07	
Respite Nursing – LPN	15 minute	13	318.65	8.74	36205.01	
Individual and Caregiver Training Total:						79049.75
Individual and Caregiver Training	15 minute	229	38.27	9.02	79049.75	
GRAND TOTAL:					30890665.17	
Total Estimated Unduplicated Participants:					3000	
Factor D (Divide total by number of participants):					10296.89	
Average Length of Stay on the Waiver:						289

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Goods and Services (self direction only) Total:						200924.06
Individual Goods and Services (self direction only)	event	75	5.95	450.25	200924.06	
Vehicle Adaptation Total:						220853.86
Vehicle Adaptation	event	41	1.27	4241.48	220853.86	
Day Supports Total:						4092152.49
Day Supports Individual	15 minute	214	1896.69	6.62	2687002.79	
Day Supports Group (2 or more clients)	15 minute	193	1847.86	3.94	1405149.70	
Adult Day Health Total:						435845.97
Adult Day Health	Day	57	178.78	42.77	435845.97	
Behavior Consultation Service Total:						275595.84
behavior consultant - Level 2	15 minute	131	88.57	21.16	245512.50	
behavior consultant - Level 3	15 minute	20	52.41	28.70	30083.34	
Transportation Total:						27161.55
Transportation	event	28	13.07	74.22	27161.55	
Specialized Consultative Services Total:						20725.10
Specialized Consultative Services	15 minute	29	43.71	16.35	20725.10	
Crisis Services Total:						25920.80
Crisis Services	15 minute	12	332.83	6.49	25920.80	
Supported Employment Total:						368843.67
Supported Employment – Individual	15 minute	105	349.57	8.28	303916.16	
Supported Employment – Group	15 minute	80	381.03	2.13	64927.51	
PERS (Personal Emergency Response System) Total:						8442.32
PERS (Personal Emergency Response System)	month	32	8.37	31.52	8442.32	
Long Term Vocational Supports Total:						157658.89
long term vocational supports - individual	15 minute	54	379.17	7.70	157658.89	
long term vocational supports - group	15 minute	0	0.00	1.91	0.00	
Home and Community Supports Total:						2915404.14
Home and Community Supports – Individual	15 minute	3354	1405.33	6.07	28610804.30	
Home and Community Supports – Group (2 or more clients)	15 minute	159	1007.84	3.39	543235.84	
Specialized Equipment and Supplies Total:						487965.49

Specialized Equipment and Supplies	event	378	56.20	22.97	487965.49	
Home Modifications Total:						147417.82
Home Modifications	event	49	1.03	2920.90	147417.82	
Crisis Respite Total:						42521.65
Crisis Respite	Day	23	6.62	279.27	42521.65	
Personal Care Total:						6229869.31
Personal Care Services	15 minute	1468	977.88	3.93	5641624.41	
Enhanced Personal Care Services	15 minute	80	1366.74	5.38	588244.90	
Augmentative Communication Devices Total:						111255.86
Augmentative Communication Device - Purchase	event	65	1.55	1072.94	108098.70	
Augmentative Communication Device – Repair and Service	event	4	1.91	413.24	3157.15	
Respite Total:						3347007.41
Respite Institutional	Day	0	0.00	231.43	0.00	
Respite Non-Institutional – Individual	15 minute	1980	360.53	3.92	2798289.65	
Respite Non-Institutional – Group (2-3 clients)	15 minute	85	739.00	3.03	190329.45	
Enhanced Respite Care – Non Institutional	15 minute	77	467.81	5.36	193074.54	
Respite Nursing – RN	15 minute	22	509.15	9.95	111452.94	
Respite Nursing – LPN	15 minute	17	348.93	9.08	53860.83	
Individual and Caregiver Training Total:						137960.22
Individual and Caregiver Training	15 minute	374	39.41	9.36	137960.22	

GRAND TOTAL:

45492162.45

Total Estimated Unduplicated Participants:

4000

Factor D (Divide total by number of participants):

11373.04

Average Length of Stay on the Waiver:

305