2024-2025 Medicaid 1915(i)-Option Set of Services

Service Code(s):	*Services Included (Sorted by Alphabetical Order):*
T2012 U4, T2012 HQ U4, T2012 GC U4, T2013 TF HQ U4, T2013 TF U4	Community Living and Supports (CL&S)
H0043 U4	Community Transition
T1019 U4, T1019 U4 TS	Individual and Transitional Support (ITS)
H2023 U4	Individual Placement & Support (IPS) for Mental Health & Substance Use
H0045 U4, H0045 HQ U4	Respite
H2023 U4, H2023 HQ U4, H2023 U3 U4, H2026 U4, H2026 HQ U4, H2026 U3 U4	Supported Employment (SE) for Member's w/ Intellectual and Developmental Disabilities (IDD) or Traumatic Brain Injury (TBI)

Codes / modifier combinations not mentioned for specialized services will be found within contracts.
For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.
When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.

General Information

Eligibility for 1915(i) services varies on a benefit-by-benefit basis. Members ages 3 and older with Intellectual/ Developmental Disabilities (IDD), Traumatic Brain Injury (TBI), Severe Mental Illness [SMI, including Severe and Persistent Mental Illness (SPMI)], Severe Emotional Disorder (SED), or severe Substance Use Disorder (SUD) are the target group for 1915i services. Members are not required to meet an institutional level of care to be eligible for 1915(i) benefits.

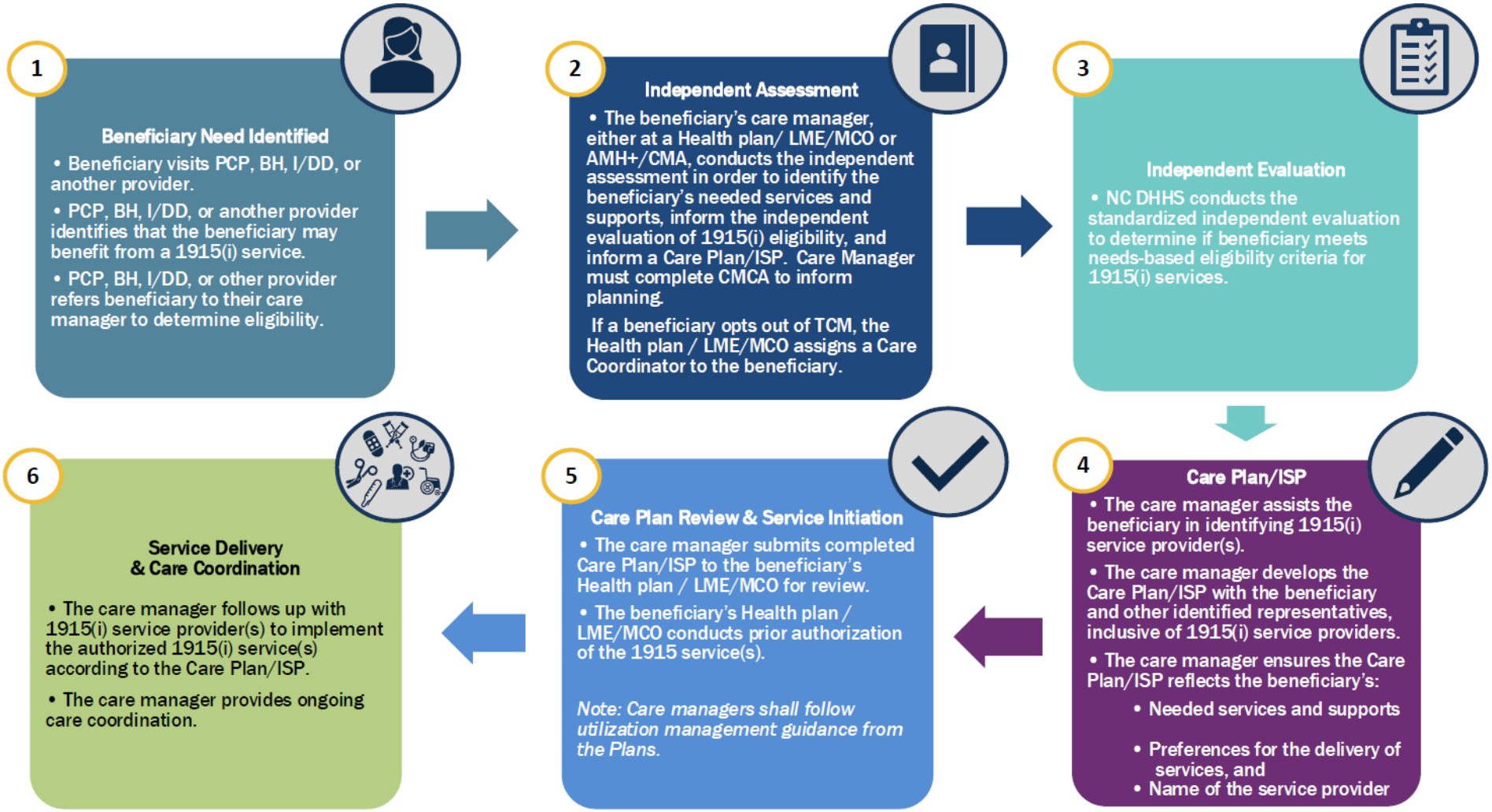
- Individuals who are enrolled in the Innovations or TBI waiver are not eligible for 1915(i) services, as they have access to similar services through those waivers.
- Individuals on the waitlist for the 1915(c) Innovations or TBI waiver are eligible to obtain 1915(i) services if they are part of a target group and meet the functional limitation and eligibility requirements.
- Individuals who are enrolled in (Community Alternatives Program for Children) CAP/C or Community Alternatives Program for Disabled Adults (CAP/DA) can receive some 1915(i) services. They cannot receive Respite or Community Transition but are eligible to receive all other services.

General Overview of the Needs-Based Criteria (Not All Inclusive)

- *Community Living and Support:* Individuals with IDD and/or TBI that have a functional deficit, can benefit from skill acquisition (e.g., self-determination, independent living), or can benefit from assistance in monitoring a health condition/ living skills.
- *Community Transition:* Individuals with IDD, SMI, SUD and/or TBI transitioning to their own community living arrangement that need initial set-up expenses/items.
- *Individual and Transitional Support:* Individuals with SUD, individuals aged 16 – 21 with SED or individuals aged 18+ with SMI with at least one deficit in an instrumental activity of daily living (e.g., meal preparation).
- Respite: Individuals aged 3+ with IDD and/or TBI, or between the ages of 3-21 with SED and/or SUD that are unable to care for themselves in the absence of their primary caregiver.
- *Supported Employment:* Individuals aged 16+ with IDD, SED, SMI, SUD and/or TBI that have expressed the desire to work, have a pattern of under/unemployment, or have educational goals that relate to employment goals.

Members may obtain 1915(i) services in the following settings: private homes, the community, group homes, integrated employment sites, or micro-enterprise. All settings where the Members obtain and receive 1915(i) services must be in integrated settings. This rule applies to all individuals in residential supports and Supported Employment (SE)/ Individual Placement Support (IPS) except where such activities or abilities are contraindicated specifically in an individual's Care Plan/ ISP and applicable due process has been executed to restrict any of the standards or rights.

Process Flow: Accessing 1915(i) Services



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The Independent Assessment

Federal rules require that individuals obtain an independent assessment to use 1915(i) services. Individuals must obtain a 1915(i) independent assessment to:

- Confirm they are eligible for 1915(i) services.
  - Note: A member's eligibility for 1915(i) services does not imply approval of/authorization of a particular 1915(i) service. Trillium must review the Prior Approval (PA) request to complete a utilization review of the service(s).
- Identify and confirm their needed services and supports.
- Provide information necessary for completing their Care Plan/ ISP.

Care managers/care coordinators must use the standardized template for the 1915(i) independent assessment issued by the Department, accessible on the Tailored Care Management webpage under Provider Resources> TCM Guidance. The assessment must be face to face and can be completed in-person or via telehealth. Through the 1915(i) assessment, care managers/care coordinators will identify whether individuals need assistance in the following domains:

- Activities of daily living (e.g., dressing)
- Instrumental activities (e.g., meal prep)
- Social and work (e.g., ability to learn new tasks)
- Cognitive/behavior (e.g., speech/language/communication)

Best Practices/Recommendations:

The 1915(i) service provider works with the care manager/care coordinator to support completion of the 1915(i) assessment. If the care manager/care coordinator is having difficulty with contacting the beneficiary, the service provider should support the care manager in getting connected with the beneficiary as delays in 1915(i) assessment completion impact service delivery. The 1915(i) service provider should work with the care manager/care coordinator to understand the status of the1915(i) assessment completion.

Following the completion of an initial 1915(i) independent assessment, an individual must obtain a 1915(i) independent assessment at least annually or when their circumstances or needs change significantly. Care managers/care coordinators will use the same 1915(i) independent assessment standardized template issued by the Department when conducting reassessments. For individuals who are engaged in TCM, completion of the annual 1915(i) independent assessment should be incorporated into the individual's annual care management comprehensive assessment to minimize the number of assessments that an individual is required to undergo. 1915(i) independent assessments and Care Plan/ISP development must always be conducted by a care manager/care coordinator and may not be conducted by a care manager extender.

The Independent Evaluation

The North Carolina Department of Health and Human Services (NCDHHS or Department) will determine eligibility for 1915(i) services. The Department, with support from Carelon (the state selected assessment vendor), will conduct the independent evaluation to determine if the

member meets the needs-based eligibility criteria for 1915(i) service(s). The Care Management entity that submitted the assessment will receive notification of eligibility decisions via email from the vendor after a decision is made.

Best Practices/Recommendations:
The standard timeframe for when a decision is rendered is approximately 2 weeks. If additional information has been requested from the assessor or the total number of assessments have increased for a review period, the review process may take longer. If a decision is not received within 2 weeks and the vendor has not requested additional information, it is recommended that the person who submitted the assessment (i.e., care manager/care coordinator) reach out to the vendor to request the status of the review. The service provider should reach out to the care manager/care coordinator to understand status of the 1915(i) eligibility.

Service Implementation Processes

- First, the individual will be referred for assessment to an organization conducting care management— either Trillium, a care management agency (a certified behavioral health or IDD provider), or an AMH+ practice (certified primary care provider) or, if a Tribal member, the Cherokee Indian Hospital Authority (CIHA). The individual must have a 1915(i) assessment completed prior to 1915(i) enrollment.
- Next, the State will conduct a brief evaluation to determine if an individual meets eligibility criteria (needs-based risk criteria, targeting criteria, and financial criteria, including confirming that the individual's income does not exceed 150% of the Federal Poverty Level (FPL)).
  - This evaluation will be conducted at the initial request, and reevaluation will be done during the individual's birth month.
  - Needs-based eligibility reevaluations are conducted at least every twelve months.
- After the individual is deemed eligible, the care manager/care coordinator works to complete the following steps:
  - Work with the member to identify a 1915(i) service provider for their 1915(i) service(s).
  - If the service provider had already been identified, the care manager/care coordinator should notify the service provider that the member has been deemed eligible for 1915(i) services.
    - The service provider must comply with conflict free case management (i.e., the provider cannot be a provider affiliated with the same organization as the member's care manager).
  - The care manager/care coordinator develops the Care Plan/ISP with the member and any other individuals identified by the member. The service provider is responsible for writing the short-term goals.
  - The care manager/care coordinator submits the completed Care Plan/ISP along with the prior authorization request to Trillium for review.
    - Note: A member's eligibility for 1915(i) services does not imply approval of/authorization of a particular 1915(i) service. Trillium will review the PA request to complete a utilization review of the service(s).
- Trillium will complete the review of the PA request and return a decision to the member's care manager/care coordinator.
- If the service request has been approved, the care manager/care coordinator works with the 1915(i) service provider to implement the authorized 1915(i) service(s) according to the Care Plan/ISP.

- Throughout the delivery of the 1915(i) services, the care manager/care coordinator provides ongoing care coordination for the 1915(i) services. For ongoing monitoring for the 1915(i) services, the care manager/care coordinator are responsible for completing the following activities monthly:
  - Monitoring Care Plan/ISP goals.
  - Maintaining close contact with the member, providers, and other members of the care team.
  - Promoting the delivery or services and support in the most integrated setting that is clinically appropriate for the member (inclusive of HCBS requirements).
  - Updating the independent assessment at least annually or as significant changes occur.
    - Note: For Members in TCM and obtaining 1915(i) services, the care manager must complete the independent assessment as part of the annual care management comprehensive reassessment.
  - Notifying Trillium of updates to 1915(i) service eligibility.
  - Monitoring of 1915(i) service delivery.
    - As a requirement of monitoring, the care manager/care coordinator must meet with the member face-to-face at least once per quarter (this can be in person or with two-way audio-visual communication) and conduct telephonic follow-up with the member for the other months in the quarter.

Person-Centered Planning and Care Plans/ Individual Support Plans

While NC Medicaid has historically required providers to complete a Person-Centered Plan (PCP) for an individual to obtain authorization for 1915(b)(3) services, the PCP will not be used for authorization of 1915(i) services. For 1915i services, the person-centered service plan is referred to as the *Care Plan* for individuals with a behavioral health need and the *Individual Support Plan (ISP)* for individuals with I/DD or TBI. A person-centered service plan is created for everyone determined to be eligible for 1915i services. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan must meet federal requirements in 42 CFR §441.725(b).

Person-centered service plans help create a sustainable system where older adults and people with disabilities live their lives by making informed choices, having full control, and accessing a broad array of quality services. Person-centered planning (and as a result the Care Plan/ ISP) should address whole-person care—physical and behavioral health needs as well as other needs, such as housing, food stability, etc., to improve health/life outcomes. It is a process of building effective and collaborative partnerships with members and working in partnership with them to create a road map for reaching the members' goals. Person-centered planning is about supporting members to realize their own vision for their lives.

Everyone has a role in promoting person-centered practices not only to adhere to person-centered service planning requirements in the regulation, but more importantly, to reach the person's vision for their good life with optimal outcomes including independence, good health, and quality of life. The care manager is responsible for driving and completing the person-centered planning process and development of

the Care Plan/ISP. Service providers must support the person-centered planning process and the development of the care plan/ISP by working with the member's care manager to ensure that the annual re-assessment happens timely to support appropriate re-authorization of services. The service provider must participate in the Care Plan/ISP meeting and support the member in updating goals or establishing new goals based on the member's progression. The service provider will identify and provide direct support staff in implementing members' goals.

Individuals who need 1915(i) services will benefit from having a single plan that documents their whole person needs, including, but not limited to, their need for 1915(i) services. Thus, for individuals in need of 1915(i) services, the Care Plan or ISP used for TCM should also be used to document an individual's need for 1915(i) services. Individuals who have opted out of TCM must work with an Trillium care coordinator to develop a Care Plan/ISP to obtain 1915(i) services.

- Note: Providers are still required to complete a PCP for certain behavioral health services as described in the applicable Clinical Coverage Policies. To reduce the time required to complete the PCP and Care Plan/ISP and ensure consistency across these documents, an individual's care manager/care coordinator should incorporate information from the individual's PCP into their Care Plan/ISP to the maximum extent possible and vice versa.

Required Components of the Care Plan and ISP:

While there is no required template for a Care Plan or ISP, TCM and federal regulation requirements outline the minimum elements that must be included in the content of a Care Plan/ISP (see Section 4.4. Care Plans and Individual Support Plans in the Tailored Care Management Provider Manual and 42 CFR §441.725(b)). The minimum elements that must be included in the content of a Care Plan/ISP include:

TCM Care Plan/ISP Required Elements (TCM 7-14)

- Plans must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate.
- Plans must include clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs (inclusive of tobacco use).
- Plans must include social, educational, and other services needed by the member.
- Plans must include measurable goals.
- Plans must include interventions, including the use and adherence to medication.
- Plans must include strategies to increase social interaction, employment, and community integration.
- Plans must include strategies to improve self-management and planning skills.
- Plans must include the intended outcomes.
- For members with I/DD, TBI, or SED, the ISP should also include support for parent/family member/caregiver, including connection to respite services, as necessary.

- Plans must include a life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving, changing foster care placement (as applicable), or entering another life transition.
- Plans must include strategies to mitigate risks to the health, well-being, and safety of the members and others.
- Plans must include an emergency/natural disaster/crisis plan.
- Plans must include information about advance directives, including Psychiatric advance directives, as appropriate.
- Plans must include names and contact information of key providers, care team members, parents/family members/caregivers/natural supports, the county child welfare worker (for members in foster care/adoption assistance and former foster youth), and others chosen by the member to be involved in planning and service delivery.
- Plans must include information on the member's foster care permanency planning goals (as applicable).

Federal Regulation Required Elements [42 CFR §441.725(b)]

- Plans must be understandable to the individual receiving services and support.
  - Note: For the written plan to be understandable, at a minimum it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Plans must prevent the provision of unnecessary or inappropriate services and supports.
- Plans must reflect the individual's strengths and preferences.
- Plans must address the assessed clinical and support needs of 1915(i) members.
- Plans must include the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
- Plans must include measurable goals [42 CFR §441.725(b)].
- Plans must include the intended outcomes [42 CFR §441.725(b)].
- Plans must include that the setting in which the individual resides is chosen by the individual.
  - Note: The setting chosen by the individual should be integrated in, and supports full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving 1915i services.
- Plans must include an emergency/natural disaster/crisis plan that includes risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Plans must identify the individual and/or entity responsible for monitoring the plan.
- Plans must ensure the member provides a signature (wet or electronic) to indicate informed consent.
- The following requirements must be documented in the Plan when modifications are made:
  - Identify a specific and individualized assessed need.
  - Document the positive interventions and supports used prior to any modifications.

  - Document less intrusive methods of meeting the need that have been tried but did not work.
  - Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
  - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - Include an assurance that the interventions and supports will cause no harm to the individual.
  - Include informed consent of the individual.
- Plans must be distributed to the individual and other people involved in the plan.

Care Plan Review & Service Initiation

Care managers will submit the member's Care Plan/ISP to Trillium for service authorization. Trillium must review and approve/deny a member's initial Care Plan/ISP within 60 Days of 1915(i) eligibility determination. 1915(i) services should begin within 45 days of Care Plan/ISP approval.

After 1915(i) eligibility approval, if a 1915(i) service is "immediately needed", care managers may complete and submit an interim plan of care to Trillium so that services may be approved. Care managers must subsequently complete the full Care Plan/ISP within 60 days of eligibility determination for 1915(i) services. "Immediately needed" 1915(i) services are defined as services that a beneficiary needs to:

- Facilitate discharge from an inpatient setting
- Prevent inappropriate placement in an inpatient setting
- Prevent placement outside the person's current living arrangement
- Address behavioral health/psychiatric conditions that place the person or others at risk of harm
- Prevent imminent loss of competitive integrated employment or offer of such employment

State Plan Amendment (SPA) Required Elements and Fact Sheet (FAQ) Clarified Required Elements

- Care Plans/ ISPs must be updated annually (SPA).
- Care Plans/ ISPs must document choice of services and providers (SPA).
- Care Plans/ ISPs must address the assessed clinical and support needs of 1915(i) members (SPA).
- Care Plans/ ISPs must incorporate results from the individual's 1915(i) independent assessment (FAQ 10-23).
- Care Plans/ ISPs must include the type, amount, and duration of 1915(i) services (FAQ 10-23).
- If applicable, the ISP must contain documentation that the beneficiary agrees with the employment of the parent or relative and has been given the opportunity to fully consider all options for employment of non-related staff for service provision. Relatives, legally responsible individuals, and legal guardians will only be paid to provide services that are for extraordinary care (exceeds the range of activities that they would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age). (SPA)
- Care Plans/ ISPs must include an arrangement for coordinating 1915(i) services (FAQ 10-23).

- Care Plans/ ISPs must ensure the member provides a signature (wet or electronic) on the Plan to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all individuals and providers responsible for its implementation. As part of the consent process, members must consent to the following (FAQ 10-23):
  - By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
  - My care manager helped me know what services are available.
  - I was informed of a range of providers in my community qualified to provide the service(s) included in my plan and I freely chose the provider who will be providing the services/supports.
  - The plan includes the services/supports I need.
  - I participated in the development of this plan.
  - I understand that my care manager will be coordinating my care with the Tailored Plan or LME/MCO network providers listed in this plan.

Service Authorization

Care managers shall follow utilization management guidance from Trillium. Service Providers should work with the member's care manager to ensure they have a copy of the service authorization, ensure the service authorization reflects the appropriate service per the care plan/ISP, and ensure 1915(i) services are provided per the approved care plan/ISP.

Ongoing Care Coordination

1915(i) care coordination is required regardless of whether a beneficiary engages in Tailored Care Management (TCM). The member's assigned care manager shall provide ongoing care coordination for 1915(i) services. As part of care planning to determine the 1915(i) services needed by a beneficiary, care managers will:

- Assist member/legally responsible person in choosing a qualified provider to implement 1915(i) service(s) (e.g., providing a list of available providers and arranging provider interviews)
- Monitor that delivery of 1915(i) services begins within 45 days of Care Plan/ISP approval
- Monitor Care Plan/ISP goals (including Home and Community Based Services (HCBS) Monitoring)
- Maintain close contact with the member, providers and other members of the care team
- Promote the delivery of services and supports in the most integrated setting that is clinically appropriate for the member
- Monitor service delivery

Service Provider Requirements for Delivery of 1915(i) Services

The 1915(i) service provider must implement the goals listed in the care plan/ISP (as appropriate). The 1915(i) service provider should also be reviewing the goals with the member to ensure that the goals are appropriate for what they are looking to achieve. To ensure the

member's needs are addressed, the 1915(i) service provider should work with the care manager to ensure that the care plan is updated appropriately to reflect any updated goals the beneficiary wants to achieve.

Since the 1915(i) service provider is meeting regularly with the member, the 1915(i) service provider should keep an open line of communication with the member's care manager to communicate any key changes with the member (including new needs, etc.). As part of the treatment team, the 1915(i) service provider should ensure that the member's care manager is:

- Up to date on any changes in the beneficiary's goals/needs
- Aware of the need to set-up necessary care planning meetings to address any changes
- Aware of the need to address any concerns during service monitoring

Best Practices/Recommendations

The 1915(i) care manager should be working with the member's 1915(i) providers and alerting them when the member's 1915(i) eligibility will end (ideally 90 days prior to that event). 1915(i) service delivery is a collaborative process between the beneficiary, 1915(i) service provider and care manager.

Conflict Free Care Management

1915(i) service providers and Tailored Care Management providers must comply with federal conflict of interest requirements, including conflict-free care management, in order to promote consumer choice and limit bias by a care manager when identifying HCBS needs and developing plans to access services. A behavioral health or I/DD provider cannot deliver both Tailored Care Management and HCBS, including 1915(i) services, to the same beneficiary.

Because 1915(i) services are HCBS, they are subject to federal conflict-free rules. This means that one provider organization cannot both deliver 1915(i) services and conduct the 1915(i) independent assessment and Care Plan/ISP development for the same individual. For additional guidance please see the Department's Guidance on Conflict-Free Care Management for Tailored Plan Members. Note: Due to HCBS conflict-free requirements, the TCM or Care Coordinate is required to submit the authorization request for all 1915(i) services. Additionally, the provider of 1915(i) services cannot be a member's TCM provider if the member is actively receiving 1915(i) services, unless CIHA is the TCM provider.

Federal conflict-free rules require the independence of persons performing evaluations, assessments, and plans of care. The person(s) performing these functions cannot be:

- Related by blood or marriage to the individual, or any paid caregiver of the individual.
- Financially responsible for the individual.
- Empowered to make financial or health-related decisions on behalf of the individual.

- Service provider(s) for the individual, or those who have interest in or are employed by a provider of 1915i services. The only exceptions are as follows:
  - For Tribal members who are exempt from enrollment in integrated Medicaid managed care, the CIHA may conduct assessment and care planning as well as provide services to the members. Individuals providing care management will not be:
    - Related by blood or marriage to the individual, or any paid caregiver of the individual.
    - Financially responsible for the individual.
    - Empowered to make financial or health-related decisions on behalf of the individual.
- Care managers may not supervise individuals providing 1915(i) services, and utilization managers and care managers may not be supervised by the same supervisor or manager.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

No 1915(i) services are subject to EPSDT.

Resources, Fact Sheets and Frequently Asked Questions (FAQs)

- North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet
- Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services
- Are psychological evaluations still required to confirm diagnosis? (FAQ from the 3/20/25 Provider webinar)
  - Plans must maintain documentation in their systems to support the member's diagnosis, which may be established through a clinical assessment, diagnostic assessment, or psychological evaluation. Eligibility for 1915(i) services requires that the member demonstrate a need for treatment or services related to an intellectual/developmental disability (I/DD), severe mental illness (SMI), severe substance use disorder (SUD), traumatic brain injury (TBI), or serious emotional disturbance (SED). Members who do not have a qualifying diagnosis or do not require treatment/services for a qualifying diagnosis will not be eligible for 1915(i) services. Plans may request additional supporting documentation of a member's diagnosis to determine medical necessity for a 1915(i) service, which could include a psychological evaluation.
- How long does it typically take from notifying the beneficiary's care manager to the services being provided? (FAQ from the 3/20/25 Provider webinar)
  - A person should receive services within 90 days of notifying the beneficiaries care manager.
- Please elaborate on the distinction between the "1915i Independent Assessment," and "1915i Independent Evaluation," and how each fit into the process/workflow. (FAQ from the 3/20/25 Provider webinar)
  - The 1915i Independent Assessment is completed by the CM/TCM on behalf of the beneficiary. The 1915i Independent Evaluation is the tool used by the State's vendor to evaluate the assessment for recommendation of approval or denial of 1915i eligibility.
- Is there standardized info required to be on care plans or ISPs? (FAQ from the 3/20/25 Provider webinar)
  - The required elements for the Care Plan and ISP are listed in the Tailored Care Management Manual in Section 4.4 "Required Content of Care Plan or ISP"

- Why is the Medicaid eligibility window not consistent with member's birth month plan year? (FAQ from the 3/20/25 Provider webinar)
  - DSS determines Medicaid eligibility based on the date the application is received.
- Do 1915i Community Living and Supports Relative as Providers (RAPs) require monthly supervision? (FAQ from the 3/20/25 Provider webinar)
  - Services delivered by relatives/legal guardians/other individuals who reside with the beneficiary are monitored monthly.

Milestone Associated with Individual Placement and Support (IPS NC-Core) Services

Trillium Health Resources, at the direction of DHHS, has implemented a way to delineate the milestone associated with the Individual Placement and Support (IPS NC-Core) services. Trillium's claims processing software accepts the IPS NC Core milestone in the Demonstration Project Identifier segment on the claim. Below are the corresponding locations per billing format:

Billing Format	Location
837 Professional (837P)	REF*P4 segment in Loop 2300
CMS 1500 submitted via Provider Direct	Field Locator 19

Milestone Associated with Supported Employment Services

Providers will submit H2023 U4– for 1915(i) Supported Employment and H2023 UA – for 1915(b)(3) Supported Employment but with the designated milestone indicator through the REF*P4 segment on the 837P or the field locator 19 on the CMS 1500:

1915(i) – H2023 U4 *1915(b)(3) Service – H2023 UA*	*1915(i) 837P Designation*	*1915(i) CMS1500 Field Locator 19*	*1915(b)(3) 837P Designation*	*1915(b)(3) CMS1500 Field Locator 19*
NC CORE Individual Placement Support Milestone 1 – Engagement	REF*P4*1915I-M1	1915I-M1	REF*P4*1915B3-M1	1915B3-M1
NC CORE Individual Placement Support Milestone 2 – Intake/Career Assessment	REF*P4*1915I-M2	1915I-M2	REF*P4*1915B3-M2	1915B3-M2
NC CORE Individual Placement Support Milestone 3 – Job Development with Retention, EIPD Ineligible	REF*P4*1915I-M3	1915I-M3	REF*P4*1915B3-M3	1915B3-M3
NC CORE Individual Placement Support Milestone 4 – Job Support and Vocational Recovery, EIPD Ineligible	REF*P4*1915I-M4	1915I-M4	REF*P4*1915B3-M4	1915B3-M4
NC CORE Individual Placement Support	REF*P4*1915I-M5	1915I-M5	REF*P4*1915B3-M5	1915B3-M5

Milestone 5 – Vocational Rehabilitation Closure, EIPD Ineligible				
NC CORE Individual Placement Support Milestone 6 – Long-Term Follow-Along	REF*P4*1915I-M6	1915I-M6	REF*P4*1915B3-M6	1915B3-M6
NC CORE Individual Placement Support Milestone 7 – Vocational Advancement	REF*P4*1915I-M7	1915I-M7	REF*P4*1915B3-M7	1915B3-M7
NC CORE Individual Placement Support Milestone 8 – Educational Attainment	REF*P4*1915I-M8	1915I-M8	REF*P4*1915B3-M8	1915B3-M8
NC CORE Individual Placement Support Milestone 9 – Successful IPS Closure Outcome Payment to Provider	REF*P4*1915I-M9	1915I-M9	REF*P4*1915B3-M9	1915B3-M9

Complete Description of Supported Employment Codes:

1915I-M1 Service - NC CORE Individual Placement Support Milestone 1 – Engagement
1915I-M2 Service - NC CORE Individual Placement Support Milestone 2 – Intake/Career Assessment
1915I-M3 Service - NC CORE Individual Placement Support Milestone 3 – Job Development with Retention, EIPD Ineligible
1915I-M4 Service - NC CORE Individual Placement Support Milestone 4 – Job Support and Vocational Recovery, EIPD Ineligible
1915I-M5 Service - NC CORE Individual Placement Support Milestone 5 – Vocational Rehabilitation Closure, EIPD Ineligible
1915I-M6 Service - NC CORE Individual Placement Support Milestone 6 – Long-Term Follow-Along
1915I-M7 Service - NC CORE Individual Placement Support Milestone 7 – Vocational Advancement
1915I-M8 Service - NC CORE Individual Placement Support Milestone 8 – Educational Attainment
1915I-M9 Service - NC CORE Individual Placement Support Milestone 9 – Successful IPS Closure Outcome Payment to Provider

General Benefit Plan Limits

- *Auth to a Different Provider:* The requested service cannot be authorized if another provider is currently authorized to provide the requested service, and two providers are not permitted to provide that service at the same time.
- *Backdated Request:* Service dates requested prior to the receipt of the authorization request cannot be authorized.
- *Contract Issue:* The requested service cannot be authorized if the provider is experiencing a contract related issue preventing the service from being approved.
- *Insurance Coverage Expired:* The requested service cannot be authorized if a member does not have active insurance coverage.
- *Missing Individual Support Plan (ISP)/Care Plan/Person Centered Plan (PCP) Information:* The requested service cannot be authorized if the ISP/ Care Plan/ PCP is missing any of the following: 1) The signature page, to include the check boxes not being complete, a missing signature, an undated signature, an electronic signature missing the date stamp, and/or if the signature is dated before the date of the

ISP/ Care Plan/ PCP; 2) Is missing a goal for the service requested; 3) Is missing the units/frequency of service requested or if the units requested exceed the frequency detailed in the ISP/ Care Plan/ PCP, and/or; 4) Is missing the Comprehensive Crisis Prevention and Intervention Plan.

- *More than 30 Days in Advance:* The service cannot be authorized if requested more than 30 days in advance. A member's clinical picture can change over time, so medical necessity for a service cannot be established based on a clinical picture that is more than 30 days old.
- *No Documentation:* The requested service cannot be authorized because the request does not include the required documentation, as detailed in the applicable Clinical Coverage Policy, the service definition, or the Benefit Plan. If required, this can include: 1) A missing or invalid service order; 2) A missing ISP/ Care Plan/ PCP; 3) A missing discharge/ transition plan, and/or; 4) Missing information on an IDD member, like a missing SNAP or a missing psychological evaluation that supports the DD diagnosis.
- *No ISP/Care Plan/PCP Update:* The requested service reauthorization cannot be authorized if an updated or revised ISP/ Care Plan/ PCP to not submitted.
- *No New Annual ISP/ Care Plan/ PCP:* The requested service cannot be authorized if the ISP/ PCP annual rewrite has not been completed. This includes when an ISP/ Care Plan/ PCP is submitted that is more than a year old.
- *Out of Catchment:* Trillium is unable to authorize the requested service if a member's Medicaid county of residence is outside of Trillium catchment area.
- *Service Exclusion:* The requested service cannot be authorized if the member is currently authorized for a service that is an exclusion to the requested service.
- *Third Party Insurance:* The requested service cannot be authorized if the member has private insurance, and the provider should seek authorization from primary insurance source. Medicaid is the payor of last resort.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions
Community Living and Supports (CLS), 1915(i) Code(s): **T2012 U4**: Community Living and Supports (only in the community, non-EVV) **T2012 GC U4**: Community Living and Supports (relative as provider lives in home, non-EVV) **T2012 HQ U4**: Community Component of CLS, Group (non-EVV) **T2013 TF HQ U4**: Community Living and Supports, Group (subject to EVV) **T2013 TF U4**: Community Living and Supports, Individual (subject to EVV)	CL&S is an individualized or group service that enables the member to live successfully in their own home, the home of their family, or natural supports and be an active member of their community. A paraprofessional assists the member to learn new skills and supports the member in activities that are individualized and aligned with the member's preferences. The goal is to maximize self-sufficiency, increase self-determination and enhance the members' opportunity to have full membership in their community. Community Living and Support enables the members to learn new skills, practice or improve existing skills, provide supervision and assistance to complete an activity to their level of independence. This service is available for members who meet the IDD or TBI eligibility criteria.	**Initial Requests**: **1.** Prior approval required. The request must be by the TCM. **2.** Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from CL&S **3.** Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i) **4.** Evidence of IDD or TBI: Required, as defined by the CCP. **5.** Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). **6.** Service Order: Required, completed by QP, Licensed BH clinician, Licensed Psychologist, MD/ DO, NP, PA **7.** Submission of applicable records that support the member has met the medical necessity criteria **Reauthorization Requests**: **1.** Prior approval required. The request must be by the TCM. **2.** Updated Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). **3.** Submission of applicable records that support the member has met the medical necessity criteria	**Length of Stay**: **1.** School-aged Members (through age 21 unless proof of graduation is provided): Up to 15 hours (60 units) a week when school is in session and up to 28 hours (112 units) a week when school is not in session **2.** Members aged 22 and up (or graduated, with proof of graduation): Up to 28 hours (or 112 units) a week **3.** Proof of Graduation: includes graduation with a degree in a standard or occupational course of study, a GED, a Certificate of Completion, or proof of the exhaustion of their educational course of study) **Units**: One unit = 15 minutes **Age Group:** Children/ Adolescents & Adults (ages 3 or above) **Level of Care**: Members must meet the IDD or TBI eligibility criteria as defined by the CCP.	CCP 8H-5: Community Living and Supports 42 CFR §441.725(b): The Person-centered Service Plan Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans) North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services APSM 45-2 Records Management and Documentation Manuals	• Relatives who live in the same home as a member who is under 18 years old may not provide CLS. • 1915(i) CLS and SE may not exceed a combined limit of 40 hrs per week. • Transportation to and from the school setting is not covered. • Individuals who are enrolled in the Innovations or TBI waiver are not eligible for 1915(i) services. • This service may not be provided during the same time as any other direct support Medicaid service. • Relatives who live in the same primary residence as beneficiary, who is over 18 years old, can provide Community Living and Supports if the relative meets the required staffing qualifications.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions

Community Transition, 1915(i)
 	
Code(s):
H0043 U4
	Community Transition provides funding for a one-time initial setup of expenses for a member transitioning from an institutional or other approved setting, into their own private residence where the member is responsible for their own living expenses. Community Transition can support a member being diverted from entry into ACHs or any institutional level of care due to preadmission, screening, and diversion efforts, provided that the member is moving to a living arrangement where they are directly responsible for their own living expenses.	**Initial Requests**:
		1. Prior approval required. The request must be submitted by TCM.
		2. Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from Community Transition
		3. Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i)
		4. Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above).
		5. Submission of applicable records that support the member has met the medical necessity criteria
			Length of Stay:
			Available up to 3 months in advance of a member's move to an integrated living arrangement, and up to 90 consecutive days post move in date.
			
			Units: One unit per episode
			
			Age Group: Adolescents & Adults (18 years of age and older)
			
			Level of Care: A primary diagnosis of IDD, TBI, SMI, SPMI, or severe SUD as defined by the CCP is required.
			
			Miscellaneous:
			• The Community Transition Checklist is to be maintained in the members' record.
			
			For individuals with IDD/TBI:
			1. Providers (non-TCMs/care coordinators) will be responsible for providing Community Transition services.
			2. The TCM/care coordinator and the provider must work together to identify the
				CCP 8H-6: Community Transition
				
				42 CFR §441.725(b): The Person-centered Service Plan
				
				Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans)
				
				North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet
				
				NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services
				
				APSM 45-2 Records Management and
					• Community Transition has a limit of $5,000 per individual during the five-year period.
					• Community Transition only covers the actual items purchased, not the time spent assisting the member to purchase them. Providers currently providing a community-based service like CST or ACT to a SMI/SUD members can bill the time spent helping members purchase these items.
					• An institutional or other approved setting can include a state developmental center, community Intermediate Care Facility, nursing facility, licensed group home, Alternative Family Living (AFL), foster home, adult care home, State Operated Healthcare Facility, or a Psychiatric Residential Treatment Facility (PRTF).
					• May be provided only in a private home or apartment with a lease in the individual's/ legal guardian's/ representative's name or a home owned by the individual.
					• May not be provided by family members.
					• Services cannot duplicate items that are currently available from a roommate.
					• Furnished only to the extent that the member is unable to meet such expense, or when the support cannot be obtained from other sources or services.
					• May not be provided to members enrolled in the CAP/C or CAP/DA wavier
					• May not be provided to a member residing in an Institution for Mental Disease (IMD) regardless of the facility type.
					• Medicaid will not cover:
					  ○ Monthly rental or mortgage expenses
					  ○ Repairs to a property

		Reauthorization Requests: Not applicable	Community Transition needs of the individuals. **3.** The TCM/care coordinator completes the care plan/ISP which indicates the request for Community Transition. **4.** The tx team then reviews the hours needed to support the individual to access Community Transition. **5.** The tx team works with the TCM/care coordinator to update the care plan/goals to address specific hours needed through the Community Living Supports service to support the individual.	Documentation Manuals	○ Regular or recurring utility bills or fees associated with lawn care, property facilities, homeowners' associations, or recurring pest eradication. ○ Household appliances (exception: a microwave) ○ Recreational items such as televisions, gaming systems, cell phones, CD or DVD players and components. ○ Food or groceries ○ Care management services or activities ○ Maintenance contracts and extended warranties

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions
Individual and Transitional Support (ITS), 1915(i) Code(s): **T1019 U4**: Individual and Transitional Support (subject to EVV) **T1019 U4 TS**: Individual and Transitional Support (only in the community, non-EVV)	Individual and Transitional Support is a direct, one-on-one service that provides structured, scheduled interventions to improve a member's ability to manage IADLs and promote independent functioning in the community and recovery. This service provides support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in employment, education, community life, maintaining housing, and residing successfully in the community. A paraprofessional assists the person in learning new skills and/or supports the person in activities that are individualized and aligned with the person's preferences.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from ITS **2.** Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i) **3.** Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). Progress made toward goals must be outlined in the care plan. **4.** Service Order: Required, completed by QP, Licensed BH clinician, Licensed Psychologist, MD/ DO, NP, PA **5.** Submission of applicable records that support the member has met the medical necessity criteria **All services are subject to post-payment review.**	**Length of Stay**: The duration and frequency must be based on MN and progress made by the member toward goals outlined in the care plan. It is expected that the service intensity titrates down as the member demonstrates improvement. **Units**: One unit = 15 minutes **Age Group**: Adolescents & Adults (16 years of age and older) **Level of Care**: A diagnosis of SED, SMI, SPMI, or severe SUD as defined by the CCP is required. **Place of Service**: Member's private primary residence, in a shelter, licensed group home, adult care home, mental health and SUD residential setting, the community or in an office setting.	CCP 8H-3: Individual and Transitional Support 42 CFR §441.725(b): The Person-centered Service Plan Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans) North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services APSM 45-2 Records Management and Documentation Manuals	• Cannot be provided during the same authorization period as Assertive Community Treatment (ACT), Community Support Team (CST), Intensive In-Home (IIH), Multi-Systemic Therapy (MST), Psychosocial Rehabilitation (PSR), IMD, or to members aged 16 to 21 who reside in a Medicaid funded group residential treatment facility or any other duplicative service. • Family members or LRP are not eligible to provide this service. • Cannot be provided if the service is otherwise available under the Rehabilitation Act of 1973 or under the Individuals with Disabilities Education Act. • Transportation, childcare services, and room & board are not covered. • Medicaid will not cover services provided to teach academic subjects. • A member transitioning from a MH or SUD residential setting or an adult care home into independent housing may receive this service up to 90 days prior to their discharge. • May not be provided in the residence of provider staff. • Cannot be provided during the same time as another direct support Medicaid service. • This service may not be provided in a group.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions
Individual Placement & Support (IPS) for Mental Health & Substance Use, 1915(i) Code(s): **H2023 U4** Providers will now designate milestone indicators through the REF*P4 segment on the 837P or the field locator 19 on the CMS 1500 instead of the previous Z-modifier combinations. This change is retroactively effective back to Date of Service 7/1/2024. Submitted IPS Core claims for dates of service 7/1/2024-9/30/2024 require a replacement claim for the milestone payment using the new approach. These and all future claims should no longer include the 'Z' modifiers.	IPS is a person-centered behavioral health service with a focus on employment and education. IPS assists in choosing, acquiring, and maintaining competitive paid employment in the community for a member 16 years and older, with significant behavioral health needs, for whom employment has not been achieved or employment has been interrupted or intermittent. IPS assists Members in securing competitive employment in the community that fits their particular needs, interests, and skills while enabling workplace success. These jobs can be part-time or full-time and can include self-employment.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from IPS. **2.** Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i) **3.** Career Profile: Required. Frequency and intensity of services must be documented in the Career Profile. **4.** Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). Must include an expressed the desire to work at the time of entrance into the program. If the member receives an enhanced service, employment and other services received must be identified by the clinical home on the integrated PCP with an attached in-depth Career Profile.	**Length of Stay**: **1.** Service does not have a hard limit. **2.** The duration and frequency at which IPS is provided must be based on medical necessity and progress made by the member toward goals outlined in the Career Profile. **3.** Services are based on the level of intensity required to acquire stable employment or interventions required for continued employment. **Units**: One unit = 15 minutes **Age Group**: Adolescents & Adults (16 years of age and older) **Place of Service**: Member's private primary residence, in a shelter, licensed group home, adult care home, the community or in an office setting. **Level of Care**: The member must meet the criteria for SED, SMI, SPMI, or severe SUD as defined by the CCP.	CCP 8H-2: Individual Placement & Support (IPS) for Mental Health & Substance Use 42 CFR §441.725(b): The Person-centered Service Plan Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans) North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services	• Services must occur in integrated environments with nondisabled individuals or in a business owned by the member. Services do not occur in licensed community day programs. • It is required that any provider delivering IPS align service delivery to the fidelity model. • IPS programs should not receive referrals for members that are receiving care management within their agency. • Services must not be provided during the same auth period as ACT. • 1915(i) SE and CLS may not exceed a combined limit of 40 hrs per week. • IPS teams shall have a zero-exclusion criterion, meaning that a member is not disqualified from engaging in employment because of readiness factors. • Members cannot be required to participate in pre-vocational training or other job readiness models. • Medicaid funds will only reimburse for services not covered by DVRS or in an employment milestone funded by DVRS. • Medicaid will not cover:

		5. Service Order: Required, completed by QP, Licensed BH clinician, Licensed Psychologist, MD/ DO, NP, PA **6.** Proof of Division of Vocational Rehabilitation Services (DVRS) Referral: IPS providers must refer a member to DVRS for eligibility determination of employment services. A referral must be made at the initiation of IPS. **All services are subject to post-payment review.**		APSM 45-2 Records Management and Documentation Manuals	○ Services provided to teach academic subjects. ○ Services that support members in set-aside jobs for people with disabilities, enclaves, mobile work crews, or transitional employment positions. ○ Services provided under the Rehabilitation Act of 1973 or special education provided under the Individuals with Disabilities Education Act (IDEA). • Federal financial participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses. • Subsidized provision of this service is not allowed. The following indicate subsidies: ○ The position would not exist if the provider agency was not being paid to provide the service. ○ The position would end if the member chose a different provider agency to provide the service. ○ The hours of employment have a one-to-one correlation with the amount of service hours authorized.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions
Respite, 1915(i) Code(s): **H0045 U4**: Respite, Individual **H0045 HQ U4**: Respite, Group	Respite services provide periodic support and temporary relief to the primary caregiver(s) from the responsibility and stress of caring for a member that requires continuous supervision due to their diagnosis. Respite services also provide the member periodic support and relief from the primary caregiver(s). Members must require assistance in at least one area of major life activity, as appropriate to the person's age, and not have the ability to care for themselves in the absence of a primary caregiver. Members must also have needs that exceed that of a child without behavioral health concerns/ developmental disabilities that could have care provided by a traditional babysitter or day care. Service specific age requirements apply.	**Initial Requests**: **1.** Prior approval required. The request must be by the TCM. **2.** Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from Respite. **3.** Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i) **4.** Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). **5.** Service Order: Required, completed by QP, Licensed BH clinician, Licensed Psychologist, MD/ DO, NP, PA **6.** Submission of applicable records that support the member has met the medical necessity criteria **Reauthorization Requests**: **1.** Prior approval required. The request must be by the TCM. **2.** Updated Care Plans/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). **3.** Submission of applicable records that support the member has met the medical necessity criteria	**Length of Stay**: No more than 1200 units (300 hours) can be provided in a care plan year, based on the members' initial care plan for the year. This is regardless of provider transitions. If a member changes providers and receives a brand-new care plan, the 1200 unit limit based on the previous plan still applies. **Units**: One unit = 15 minutes **Age Group & Level of Care**: • Aged 3 through 21 w/ a documented primary diagnosis of a SED (as defined by the CCP) or primary diagnosis of SUD, severe (as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)) *OR* • Aged 3 and older w/ a primary diagnosis of IDD or TBI, as defined by the CCP or the DSM or a genetically diagnosed syndrome that is typically associated with IDD	CCP 8H-4: Respite 42 CFR §441.725(b): The Person-centered Service Plan Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans) NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for 1915(i) Services North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet APSM 45-2 Records Management and Documentation Manuals	• Respite must not be provided by relatives or legal guardians if they live in the same home as the member. Respite care may not be provided by any person who resides in the individual's primary place of residence. • The member receiving this service must live in a non-licensed setting, with non-paid caregiver(s). Exception: Those residing in a licensed or unlicensed AFL or Therapeutic Foster Care (TFC). • Respite may not be billed on the same day as Residential Supports. • Staff sleep time is not billable. • This service is not available to members who reside in a 5600B or 5600C licensed facility. • Emergency care applies to family emergencies and does not include out of home crisis. • This service may not be used as a regularly scheduled daily service for individual support. • Respite may not be used for members who are living alone or with a roommate. • Members enrolled in the CAP/C or CAP/DA waiver are not eligible for Respite services. • Respite is not telehealth eligible.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)	Exclusions, Limitations & Exceptions
Supported Employment (SE) for Member's w/ IDD or TBI, 1915(i) Code(s): **H2023 U4**: Supported Employment, Initial **H2023 HQ U4**: Supported Employment, Initial (Group) **H2023 U3 U4**: IDD Supported Employment, Initial **H2026 U4**: Supported Employment Maintenance **H2026 HQ U4**: Supported Employment Maintenance (Group) **H2026 U3 U4**: IDD Long Term Vocational Supports	SE services provide assistance with choosing, acquiring, and maintaining a job. The service is available when competitive, integrated employment (CIE) has not been achieved or has been interrupted or intermittent. SE services may be either temporary or long-term. The intent of SE service is to assist a member with developing skills to seek, obtain and maintain competitive, integrated employment or develop and operate a micro-enterprise. Employment positions are found based on members' preferences, strengths, and experiences. Job finding is used to explore options for competitive, integrated employment and is not based on placement from a pool of jobs that are available or set aside specifically for individuals with disabilities.	**Initial Requests**: **1.** Prior approval required. The request must be by the TCM. **2.** Independent Assessment: Required, completed by a TCM or the CIHA for Tribal members that indicates the Member would benefit from SE. **3.** Independent Evaluation: Required, completed by DHB/ Carelon to determine eligibility for 1915(i) **4.** Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). **5.** Service Order: Required, completed by QP, Licensed BH clinician, Licensed Psychologist, MD/ DO, NP, PA **6.** DVRS Documentation: Proof of Ineligibility Decision Document that DVRS provides; OR documentation from a DVRS Counselor that DVRS funded supports have ended. **7.** Submission of applicable records that support the member has met the medical necessity criteria	**Length of Stay**: **1. Pre-employment and Employment Stabilization Phase**: A maximum of 20 hours (80 units) per week for up to 180 days of services for initial job development, training, and support. If the member obtains employment and their schedule and support needs require more than 20 hours a week of services, add'l hours can be authorized. **2. Employment Stabilization Phase**: Based on the members' work schedule and support needs, not to exceed 40 hours a week (160 units). Services can be auth'd for up to 365 days if the work schedule/ needs are not anticipated to change. **3. Long-Term Supported Employment Phase**: For a member who is stable in their employment and has minimal support needs, a maximum of 10 hours (40 units) per month may be approved annually for periodic long-term support. If there is an increased support need,	CCP 8H-1: Supported Employment for I/DD and TBI 42 CFR §441.725(b): The Person-centered Service Plan Tailored Care Management Provider Manual (Section 4.4. Care Plans and Individual Support Plans) North Carolina's Transition of 1915(b)(3) Benefits to 1915(i) Fact Sheet NC Medicaid Managed Care Provider Playbook Fact Sheet Processes and Frequently Asked Questions for	• Employment Phases: ○ **Pre-employment Phase**: If the Member needs more than 180 consecutive days for initial job development, additional requests can be made and must provide justification as to why additional job development time is necessary. No more than 6 months in a typical situation. ○ **Employment Stabilization Phase**: It is critical that job fading occurs early during this phase to allow the Member to develop on-the-job and natural supports. The Employment Stabilization Phase is not expected to exceed a year. ○ **Employment Stabilization Phase**: should not continue solely as a means of transportation to and from the worksite. An individualized plan of assistance must be provided to identify appropriate long-term modes of transportation and how to use them. • Services must occur in integrated environments with nondisabled individuals or in a business owned by the member. Services do not occur in licensed community day programs. • IPS programs should not receive referrals for members that are receiving care management within their agency. • 1915(i) SE and CLS may not exceed a combined limit of 40 hrs per week. • SE may not be provided by family members who live in the same household as the member.

		Reauthorization Requests: **1.** Prior approval required. The request must be by the TCM. **2.** Updated Care Plan/ ISP: Must include the information/ requirements detailed in the TCM Provider Manual and federal PCP requirements (see PCP section above). Detailed documentation of goals specific to long-term support needs must reflect how the services are received and preparing the member for working as independently as possible. **3.** Submission of applicable records that support the member has met the medical necessity criteria.	add'l hours may be authorized. For a member with ongoing support needs, SE may be authorized for the number of hours necessary to support the member to remain stable in their employment; not to exceed 40 hours (160 units) a week. **Units**: One unit = 15 minutes **Age Group**: Age 16 and older **Place of Service**: Member's job site or a community setting where Supported Employment service activities are taking place. **Level of Care**: The member must meet the criteria for IDD or TBI as defined by the CCP.	1915(i) Services APSM 45-2 Records Management and Documentation Manuals	• SE Group is not covered unless the members work in the same CIE setting and have support needs at the same day(s) and time(s) and the needs of the members can all be met by the staff. The max group size is 3 members to 1 staff. • May not be provided during the same time/ at the same place as any other direct support Medicaid service. • May not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973 or under the Individuals with Disabilities Education Act. • A provider shall not bill both DVRS and UM Contractor at the same time for duplicative Supported Employment activities. Medicaid is always the payer of last resort. • May not be provided to a member living in an ICF-IID. • FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses. • Subsidized provision of this service is not allowed. The following indicate subsidies: ○ The position would not exist if the provider agency was not being paid to provide the service. ○ The position would end if the member chose a different provider agency to provide the service. ○ The hours of employment have a one-to-one correlation with the amount of service hours authorized