NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

September 15, 2022

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2022-0026

Dear Mr. Scott:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 3.1-I Pages 1 – 47; Attachment 4.19-B Supplement 7, Pages 1-2; Attachment 2.2-A Supplement 4, Pages 1-2.

This state plan change is to add services through the 1915(i) benefit. These services include Community, Transition, Respite, Supported Employment, Individual Placement Supports, Community Living and Supports, and Individual and Transitional Supports. These services will be replacing services that are currently being provided under a 1915(b)(3) authority which will end 11/30/22. These services are not available under the 1115 demonstration waiver, so after Tailored Plan launch in December of 2022 individuals receiving these services through the (b)(3) waiver would lose access to them.

The proposed effective date is December 01, 2022

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Cecilia Williams at (919) 270-2530.

Sincerely,

DocuSigned by:
Dave Richard
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Dave Richard
Deputy Secretary

Enclosures

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

NC MH/IDD/SUD/TBI (i) option Services

- Supported Employment/Individual Placement Supports
- Individual and Transitional Support
- Respite
- Community Living and Support
- Community Transition

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
x	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
x	**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:*
	NC MH/IDD/SUD Waiver has been previously approved and authorizes North Carolina's PIHPs. An amendment will be submitted to add oversight of the (i). The following PIHPs will furnish 1915(i) State Plan HCBS under the (b) waiver. Alliance Behavioral Healthcare - Cumberland, Durham, Johnston, Mecklenburg, Orange,

Wake
Eastpointe - Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, Wilson
Partners Behavioral Health Management - Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, Yadkin
Sandhills Center - Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Rockingham
Trillium Health Resources - Bladen, Brunswick, Carteret, Columbus, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington
Vaya Health - Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, Yancey

The (b) waiver will have populations that have been legislatively excluded from the 1115. CAP C and CAP DA waivers, Dual eligible not on Innovations or TBI waiver, Health Insurance Premium Program, Long stay nursing facility, State VA Home, as well as Child and Family Specialty Plan (CFSP) eligible that choose not to enroll in an SP or TP prior to CFSP launch and Tribal Option members that have chosen not to enroll in the Tailored Plan.

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

x	§1915(b)(1) (mandated enrollment to managed care)	x	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	x	§1915(b)(4) (selective contracting/limit number of providers)

Please note that the (i) option will need to be approved in concurrent with the (b) waiver amendment for this transitions.

☐ **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:

X **A program authorized under §1115 of the Act.** *Specify the program*: **North Carolina Section 1115 Demonstration Project**

The 1115 waiver has been previously approved and authorizes Tailored Plans, specialized MCOs targeted toward individuals with serious mental illness, severe emotional disturbance, severe substance use disorder, intellectual/developmental disabilities, and traumatic brain injury. 1915(i) services under this authority will be provided by Tailored Plans and will be available statewide.

The following PHPs will furnish 1915(i) State Plan HCBS under the 1115.
Alliance Behavioral Healthcare - Cumberland, Durham, Johnston, Mecklenburg, Orange, Wake

[redacted]	Eastpointe - Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, Wilson Partners Behavioral Health Management - Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, Yadkin Sandhills Center - Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Rockingham Trillium Health Resources - Bladen, Brunswick, Carteret, Columbus, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington Vaya Health - Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, Yancey

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	X	The Medical Assistance Unit *(name of unit)*:	The Division of Health Benefits
	O	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
O	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☐	☐	☑	☐
2 Eligibility evaluation	☐	☐	☑	☐
3 Review of participant service plans	☐	☐	☑	☐
4 Prior authorization of State plan HCBS	☐	☐	☑	☐
5 Utilization management	☐	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10Quality assurance and quality improvement activities	☐	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

LME-MCOs and Tailored Plans perform these activities under a contract with the State Medicaid agency.

1. Individual State Plan HCBS enrollment,
2. Eligibility evaluation
3. Review of participant service plans
4. Prior authorization of State plan HCBS
5. Utilization management
8. Establishment of a consistent rate methodology for each State Plan HCBS
10. Quality assurance and quality improvement activities.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- 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
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The State proposes to allow the Cherokee Indian Hospital Authority (CIHA) to conduct assessment and care planning though they may also provide services to the members. Services offered by tribal entities and tribal staff are more culturally respected by the members being serviced than those provided by nontribal providers and we would like to offer this option to ensure that tribal members have an option to receive these offered by tribal providers. CHIA has assured they will make every effort to ensure that the staff doing care management are not the same branch, section, division, office doing the service delivery, though they may report to the same CEO, Secretary, Director, Supervisor or Manager. They feel like we can put in place firewalls to meet the intent of conflict free case management without compromising the sovereignty of Tribes designing and organizing their services arrangements. They also feel we can establish a procedure to address any potential or perceived conflict of interest without totally disallowing the use of the existing infrastructure.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	12/1/22	11/30/23	10,364
Year 2	12/1/23	11/30/24	
Year 3	12/1/24	11/30/25	
Year 4	12/1/25	11/30/26	
Year 5	12/1/26	11/30/27	

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency

X	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Evaluations/Reevaluations will be performed by the PHP or PIHP.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

- Evaluations/Reevaluations will be performed by the PHP or PIHP. Minimum qualifications are bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
    - If serving members with BH needs: Two (2) years of experience working directly with individuals with BH conditions.
    - If serving members with an I/DD or TBI: Two (2) years of experience working directly with individuals with I/DD or TBI.
    - If the member is dually diagnosed with a BH condition and I/DD or TBI, staff must have two years of experience in the primary diagnosis area and must have training in the other area.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Tailored Plan/LME-MCOs will conduct a brief evaluation to determine if an individual will potentially meet eligibility criteria (targeting, risk, and financial criteria). If they are already receiving services, screening may be done using information in the PHP or PIHP system. This evaluation will be at the initial request and reevaluation will done during the individuals birth month.

The individual will then be referred to for assessment to an organization conducting care management—either the Tailored Plan/LME-MCOs, a care management agency (behavioral health or I/DD provider certified by the State), or an advanced medical home plus (AMH+ practice (primary care provider certified by the State). Please note that Tailored Plan/LME-MCOs will have a firewall between the unit of the agency that does the evaluation and the unit that provides care management.

4. ☑ Reevaluation Schedule. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Supported Employment/IPS

1) Individuals who are 16 years of age and older with Intellectual or Developmental disabilities or TBI who need support in obtaining or maintaining competitive employment and desire to be employed.

2) The beneficiary is 16 years of age and older; and
A. Has a primary diagnosis of a serious mental illness (SMI), including severe and persistent mental illness (SPMI): or
B. Has a primary diagnosis of a serious emotional disturbance (SED); or
C. Has a primary diagnosis of substance use disorder, severe
AND
Expresses the desire to work at the time of admission to the program, and has an established pattern of unemployment, underemployment, or sporadic employment; or the beneficiary has educational goals that relate to employment goals; and requires assistance in obtaining or maintaining employment in addition to what is typically available from the employer because of functional limitations as described above and behaviors associated with the individual's diagnosis.

Individual and Transitional Support
3) Children aged 16 to 21 with SED who are transitioning to adulthood with at least one deficit in an instrumental activity of daily living (IADL)

4) Adults aged 18 and older with a diagnosis of Serious Mental Illness (SMI) or Serious Persistent Mental Illness SPMI) with at least one deficit in an instrumental activity of daily living (IADL)

Respite
5) Adults and children with Intellectual/Developmental Disabilities and TBI, and children 3-20 with Severe Emotional Disturbance or severe SUD who are unable to care for themselves in the absence of their primary caregiver.

Community Living and Support
6) Intellectual or Developmental Disability or TBI with at least one functional deficit who can benefit from either skill acquisition in one area from the following: interpersonal, independent living, community living, self-care, and self-determination OR assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, and interpersonal skills.

Community Transition
7) Adult with IDD, TBI, SMI, or severe SUD who are moving from a living arrangement which they do not control into their own home in the community who need initial set-up expenses/items.

6. x **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from

the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Functional deficits due to I/DD, TBI, SED,SMI or SUD.	Conditions that are considered when assessing a beneficiary for nursing facility level of care include the following: 1. Need for services that, by physician judgment, require: A. A registered nurse for a minimum of 8 hours daily; and Need for 24-hour observation and assessment of resident needs by a registered nurse or a licensed practical nurse. 3. Need for administration and control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 13O.0202, 21 NCAC 36.0401 and 21 NCAC 36.0403, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for teaching, supervision and evaluation). 4. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities; such measures may include the following: A. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transferring, and ambulation); B. Using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures; or C. Training in ambulation and gait, with or without assistive devices 5. Special therapeutic diets: nutritional needs under the supervision and monitoring by a registered dietician. 6. Nasogastric and gastrostomy tubes: requiring monitoring and observation: A. Tube with flushes; B. Medications administered through the tube; C. Supplemental bolus feedings. 7. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan: A. Nebulizer usage; B. Pulse oximetry; C. Oral suctioning. 8. Wounds and care of decubitus ulcers or open areas. 9. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan. 10. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan. 11. Diabetes, when daily observation of dietary intake and medication administration is required for proper physiological control. 12. Cognitive disabilities impacting the ability of a resident to independently perform activities of daily living, resulting in the need for hands on assistance. Additional criteria in our Nursing Policy:	Active treatment is a continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services described in 42 CFR 483.440. In order to be Medicaid-certified at an ICF/IID level of care, a beneficiary shall meet the following criteria: a. Require active treatment necessitating the ICF/IID level of care; and b. Have a diagnosis of Intellectual Disability per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, text (DSM-5), or a condition that is closely related to mental retardation. 1. Intellectual Disability is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18. 2. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets ALL of the following conditions: A. is attributable to: i. Cerebral palsy, epilepsy; or ii. 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 Intellectually Disabled persons, and requires treatment or services similar to those required for these persons; B. The related condition manifested before age 22; C. Is likely to continue indefinitely; and D. Have	The NC TBI Level of Care Assessment tool is used to determine the initial Level Of Care (LOC) For Specialty Hospital Level of Care, the following must be met: 1. Behavior Assessment Grid indicates impairment that is present and severe AND requires the availability of intensive behavior intervention in two or more of the following areas: • Damage to property, • Inappropriate sexual activity, • Injury to others, Injury to self, • Physical aggression 2. Behavioral Support at one of the following levels: • Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic or demanding. Person responds to cues. “Occasional” is defined as less than 4 times per week and needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive but responds to redirection. “Regular” is defined as 4 or more times per week. • Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or acting in a sexually aggressive manner. Person may be resistant to redirection. • Needs and receives behavior management and staff intervention because person

	https://medicaid.ncdhhs.gov/media/11303/open For TBI waiver: The NC TBI Level of Care Assessment tool is used to determine the initial Level Of Care (LOC)for each waiver beneficiary. Annual re-assessment of LOC is confirmed by the care coordinator For Nursing Facility Level of Care, the following must be met: 1. Modified Rancho Los Amigos © Level of Cognitive Functioning Level IV through VIII. 2. Cognitive support needs – One impairment in Awareness, Communication, Judgement, Memory, Planning, Problems Solving skills AND one other cognitive skill OR Impairment in three or more cognitive functions with at least two of the three functions requiring "Present / Requires frequent support" or "Present and severe, requires availability of "24-hour support" or monitoring level of intensity. 3. Behavior Assessment Grid indicates impairment in two or more of the following areas: • Agitation • Impulsivity • Intrusiveness • Legal history after brain injury • Pica • Socially offensive behavior • Susceptibility to victimization • Verbal aggression • Wandering/ Elopement • Withdrawal • Damage to Property • Inappropriate sexual activity • Injury to others • Injury to self • Physical Aggression 4. Behavioral Support at one of the following levels: • Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic or demanding. Person responds to cues. "Occasional" is defined as less than 4 times per week. • Needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive, but responds to redirection. "Regular" is defined as 4 or more times per week. • Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or • Needs and receives behavior management and staff intervention because person is physically abusive to self and others. Person may physically resist redirection. 5. Requires level of specialized cognitive and behavioral support(s) available in a nursing facility that provided brain injury services.	Intellectual Disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (refer to Attachment B): i. Self-Care (ability to take care of basic life needs for food, hygiene, and appearance) ii. Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally) iii. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations) iv. Mobility (ambulatory, semi-ambulatory, non-ambulatory) v. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life) vi. Capacity for independent living (age-appropriate ability to live without extraordinary assistance).	is physically abusive to self and others. Person may physically resist redirection. 3. Requires services and/or supports that exceed services in TBIW-NF. 4. Requires a 24-hour plan of care that includes a formal behavioral support plan. 5. Requires level of care and behavioral support available in a neurobehavioral hospital; available intensive behavior intervention. A person does not have to be a resident of a neurobehavioral hospital to require this level of care.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Children and adults with I/DD, adults with TBI, children with SED, adults with SMI or adults and children with severe SUD

☑ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

North Carolina currently provides many of the services that would be covered under 1915(i) authority through 1915(b)(3) authority. The State proposes to transition all beneficiaries currently authorized to receive 1915(b)(3) services upon implementation of the (i) option with reassessment/evaluation occurring no more than 1 year from the implementation of the (i) option with reevaluation during their birth month thereafter. This will ensure that no individuals lose services during the transition from (b)(3) to (i).

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	X	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Individuals will reside in their own homes, with their families, in licensed or unlicensed alternative family living arrangements (AFLs), licensed foster care homes, or group homes licensed under 10A NCAC 27G.5600. If appropriate, services may be provided in these settings or in the community.

The following HCBS Characteristics must be found in all settings:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community;
2. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
3. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
4. Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);
5. Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected;
6. Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices;
7. They also facilitate individual choice regarding services and supports, and who provides these.

The following additional HCBS Characteristics must be met in Provider Owned or Controlled Residential Settings:

8. Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;
9. Provide privacy in sleeping or living unit;
10. Provide freedom and support to control individual schedules and activities, and to have access to food at any time;
11. Allow visitors of choosing at any time;
12. Are physically accessible

Any modification of these conditions under 42 CFR 441.710(a)(1)(F) must be supported by a specific assessed need and justified in the person-centered service plan.

All settings where the beneficiaries obtaining 1915(i) services reside and receive 1915(i) services will meet and continue to meet the Federal HCBS standards prior to providing services and therefore, will be in the Integrated Settings. These HCBS rules will be applied to all individuals in residential supports and supported employment except where such activities or abilities are contraindicated specifically in an individual's person-centered plan and applicable due process has been executed to restrict any of the standards or rights.
We have assessed the 1915(i) service settings and determined that the services that the HCBS Final Rule will potential impact are:

- Supported Employment
- Individual and Transitional Support (when used to support someone in a residential setting when provided by the residential provider)
- Community Living and Supports (when used to support someone in a residential setting and provided by the residential provider)

Refer to North Carolina DHHS's HCBS Transition Plan for additional information on the HCBS process. Please note that (i) option providers must comply to provide (i) option services.

Services provided to individuals in private homes are assumed to meet HCBS requirements

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. 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 meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

- Minimum qualifications are bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
  - If serving members with BH needs: Two (2) years of experience working directly with individuals with BH conditions.
  - If serving members with an I/DD or TBI: Two (2) years of experience working directly with individuals with I/DD or TBI.
  - If the member is dually diagnosed with a BH condition and I/DD or TBI, staff must have two years of experience in the primary diagnosis area and must have training in the other area.

**To the extent possible, working the Eastern Band of the Cherokee Indians, the State would like to allow CIHA to conduct the assessment for Tribal members.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

- Minimum qualifications are bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
    - If serving members with BH needs: Two (2) years of experience working directly with individuals with BH conditions.
    - If serving members with an I/DD or TBI: Two (2) years of experience working directly with individuals with I/DD or TBI.
    - If serving members with LTSS needs: Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The Care Plan or Individual Support Plan is developed through a person-centered planning process led by the beneficiary and/or legally responsible person for the beneficiary to the extent they desire. Person--centered planning is about supporting beneficiaries to realize their own vision for their lives. Person-centered planning (and as a result the person-centered plan) 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 participants and working in partnership with them to create a road map for the ISP for reaching the beneficiary's goals. The planning process is directed by the beneficiary including who is involved with their planning and identifies strengths and capabilities, desires and support needs.

Please note that the Tribe and some PHPs/PIHPs use the elements of the ISP or PCP but do not use the standardized template. The State has approved this when all of the elements are present.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The PHP/PIHPs inform the beneficiary of the right to provider choice and how to access provider directories. The Care Manager will confirm provider choice with the beneficiary or assist them in locating a provider of (i) option services. Provider choice must be attested by the beneficiary in the plan.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The Individualized Service Plan (ISP) or PCP is submitted by the care manager to the PHP or PIHP in which the beneficiary is enrolled.

9. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☐	Other (*specify):*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supported Employment – IDD and TBI
Service Definition (Scope)*:*	
The intent of Initial Supported Employment is to assist individuals with Intellectual or Developmental Disabilities or TBI in developing skills to seek, obtain and maintain competitive employment or develop and operate a micro-enterprise. The employment positions are found based on individual preferences, strengths, and experiences.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Individuals who are 16 years of age and older with Intellectual or Developmental disabilities or TBI who need support in obtaining or maintaining competitive employment and desire to be employed.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*

	The service includes transportation to and from the service and/or the job site, only if there is no other viable and more cost-effective alternative available to the beneficiary. Exclusions: FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2. Payments that are passed through to users of supported employment programs; or 3. Payments for training that are not directly related to a beneficiary's supported employment program. The following types of situations are indicative of a provider subsidizing its participation in supported employment: 1. The job/position would not exist if the provider agency was not being paid to provide the service. 2. The job/position would end if the individual chose a different provider agency to provide service. 3. The hours of employment have a one-to-one correlation with the number of hours of service that are authorized. For individuals who are eligible for educational services under the Individuals with Disability Educational Act, Supported Employment does not include transportation to/from school settings. This includes transportation to/from the individual's home, provider home where the individual may be receiving services before or after school or any other community location where the individual may be receiving services before or after school. Supported Employment services occur in integrated environments with non-disabled individuals or is a business owned by the beneficiary. Supported Employment services do not occur in licensed community day programs. While it is not prohibited to both employ an individual and provide service to that same individual, the use of Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service is prohibited.
☑	Medically needy *(specify limits):*
	Same as categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Provider Agencies	N/A	N/A	• Meet provider qualification policies, procedures, and standards established DHB and enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, communication bulletins and other published instructions. • National accreditation within

			one year of enrollment (COA, CARF, CQL or Joint Commission)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Provider Agencies	NC Medicaid or Vendor	Upon enrollment and every three years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supported Employment– MH/SUD (Individual Placement Support)

Service Definition (Scope)*:*

Individual Placement and Support (IPS) is a person-centered, behavioral health service with a focus on employment, that provides assistance in choosing, acquiring, and maintaining competitive paid employment in the community for individuals 16 years and older for whom employment has not been achieved or employment has been interrupted or intermittent

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Eligibility Criteria

The beneficiary is 16 years of age and older; and

A. Has a primary diagnosis of a serious mental illness (SMI), including severe and persistent mental illness (SPMI): or
B. Has a primary diagnosis of a serious emotional disturbance (SED); or
C. Has a primary diagnosis of substance use disorder, severe

AND

Expresses the desire to work at the time of admission to the program, and has an established pattern of unemployment, underemployment, or sporadic employment; or the beneficiary has educational goals that relate to employment goals; and requires assistance in obtaining or maintaining employment in addition to what is typically available from the employer because of functional limitations as described above and behaviors associated with the individual's diagnosis.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions

related to sufficiency of services.
(Choose each that applies):

☑ Categorically needy *(specify limits):*

An individual may receive IPS services from only one IPS provider organization during any active authorization period for this service.
All IPS services are provided on an individual basis by IPS team members, not in groups, facilities, and/or congregate settings.

The following actives are not covered under IPS:
a) Services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide, or an academic tutor;
b) Pre-vocational classes;
c) Supports and/or services to help individuals with volunteering;
d) Set-aside jobs for people with disabilities, such as enclaves;
e) Group employment/work crews;
f) Transitional employment;
g) Group employment searches or classes;
h) Habilitative services for the individual to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings;
i) Non-employment related transportation for the individual or family;
j) Any services provided to family, friends, or natural supports of the individual receiving IPS to address problems not directly related to the individual's issues and not listed on the Person-Centered Plan and/or Employment Plan;
k) Clinical and administrative supervision of staff; or
l) Time spent in meetings where the eligible individual is not present.

Additionally, if an eligible individual is a shared case between DHB and the Division of Vocational Rehabilitation Services (DVR), Medicaid funds will only reimburse for services not covered by DVR or in a DVR milestone.

Services may not occur in segregated settings or sheltered workshops.
While it is not prohibited to both employ an individual and provide service to that same individual, the use of Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service is prohibited.

☑ Medically needy *(specify limits):*

Same as categorically needy

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Provider Agencies	n/a	n/a	• Meet provider qualification policies, procedures, and standards established DHB and enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G;

			• Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, communication bulletins and other published instructions. • National accreditation within one year of enrollment (COA, CARF, CQL or Joint Commission)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Provider Agencies	NC Medicaid or Vendor	Upon enrollment and every three years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Individual and Transitional Support

Service Definition (Scope)*:*

This service is a direct, one-on-one service intended to teach and assist individuals in carrying out Instrumental Activities of Daily Living (IADLs) including, but not limited to meal preparation, medication management, grocery shopping, money management, so that they can live independently in the community.

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 to reside successfully in the community.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Children aged 16 to 21 with SED who are transitioning to adulthood with at least one deficit in an instrumental activity of daily living (IADL) or

Adults aged 18 and older with a diagnosis of Serious Mental Illness (SMI) or Serious Persistent Mental Illness SPMI) with at least one deficit in an instrumental activity of daily living (IADL)

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

a. This service may not be provided in a group. Housekeeping, homemaking, or basic services sole for the convenience the caregiver of the beneficiary receiving the services are not covered.

b. Individual and Transitional Support may not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973, P.L. 94-142, or under the Individuals with Disabilities Education Act, 20 U.S.C. 1401 et seq.).

c. Individual and Transitional Support may not be provided during the same time / at the same place as any other direct support Medicaid service.

d. Individual and Transitional Support may not be provided during the same authorization period as Assertive Community Treatment or Community Support Team.

e. Individual and Transitional Support may not be provided to children ages 16 up to 21 who reside in a Medicaid funded group residential treatment facility.

f. Individual and Transitional Support may not be provided by family members.

g. This service may be provided up to 60 hours per month.

☑ Medically needy *(specify limits):*

Same as categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Provider Agencies	n/a	n/a	• Meet provider qualification policies, procedures, and standards established DHB and enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, communication bulletins and other published instructions. • National accreditation within

			one year of enrollment (COA, CARF, CQL or Joint Commission)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Provider Agencies	**NC Medicaid or Vendor**	**Upon enrollment and every three years.**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Respite

Service Definition (Scope)*:*

Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, and Therapeutic Foster Care. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. This service also enables the individual to receive periodic support and relief from the primary caregiver(s) at his/her choice. Respite may be utilized during school hours for sickness or injury. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver(s) is the person principally responsible for the care and supervision of the beneficiary and must maintain his/her primary residence at the same address as the beneficiary.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

This service is provided to adults and children with Intellectual/Developmental Disabilities and TBI, and children 3-20 with Severe Emotional Disturbance or severe SUD who are unable to care for themselves in the absence of their primary caregiver.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	a. This service may not be used as a regularly scheduled daily service in individual support. b. This service is not available to beneficiaries who reside in licensed facilities that are licensed as 5600B or 5600C. Staff sleep time is not reimbursable. c. Respite services are only provided for the individual; other family members, such as siblings of the individual, may not receive care from the provider while Respite Care is being provided/billed for the individual. d. Respite Care is not provided by any person who resides in the individual's primary place of residence. e. Federal Financial Participation (FFP) 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. f. For individuals who are eligible for educational services under Individual's with Disability Educational Act, Respite does not include transportation to/from school settings. This includes transportation to/from beneficiary's home, provider home where the beneficiary is receiving services before/after school or any community location where the beneficiary may be receiving services before or after school. g. Respite may not be used for beneficiaries who are living alone or with a roommate. h. There is a limit of 300 hours per year of Respite per beneficiary.
☑	Medically needy *(specify limits):*
	Same as categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Provider Agencies, facility based and in-home services	NC G.S. 122 C (specific to facility Respite providers	n/a	• Meet provider qualification policies, procedures, and standards established DHB and enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, communication bulletins and other published instructions. • National accreditation within one year of enrollment (COA, CARF, CQL or Joint

			Commission)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Provider Agencies	NC Medicaid or Vendor	Upon enrollment and every three years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Community Living and Support

Service Definition (Scope)*:*

Community Living and Support is an individualized service that enables the beneficiary to live successfully in his/her own home or the home of his/her family or natural supports and be an active member of his/her community. A paraprofessional assists the person to learn new skills and/or supports the person in activities that are individualized and aligned with the person's preferences. The intended outcome of the service is to increase or maintain the person's life skills or provide the supervision needed to empower the person to live in the home of his/her family or natural supports, maximize his or her self-sufficiency, increase self- determination and enhance the person's opportunity to have full membership in his/her community. Community Living and Support enables the person to learn new skills, practice and/or improve existing skills. Areas of skill acquisition are: interpersonal, independent living, community living, self-care, and self-determination. Community Living and Support provides supervision and assistance for the person to complete an activity to his/her level of independence. Areas of support consist of assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, and interpersonal skills.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Intellectual or Developmental Disability or TBI with at least one functional deficit who can benefit from skill acquisition in one area noted above.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Adult @ 28 hours/week; Child @ 15 hours/week (when in school) or 28 hours/week (when not in school) For individuals who are eligible for educational services under Individual's with Disability Educational Act, Community Living and Supports does not include transportation to/from school settings. This includes transportation to/from beneficiary's home, provider home where the beneficiary is receiving services before/after school or any community location where the beneficiary may be receiving services before or after school.
☑	Medically needy *(specify limits):*
	Same as categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Provider Agencies	n/a	n/a	• Meet provider qualification policies, procedures, and standards established DHB and enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and state requirements. This includes the North Carolina Department of Health and Human Services statutes, rules, policies, communication bulletins and other published instructions. • National accreditation within one year of enrollment (COA, CARF, CQL or Joint Commission)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Provider Agencies	NC Medicaid or Vendor	Upon enrollment and every three years.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Community Transition
Service Definition (Scope)*:*	
The purpose of Community Transition is to provide initial set-up expenses for adults to facilitate their transition from a State Developmental Center (ICF-IID), community ICF-IID, Group Home, nursing facility or another licensed living arrangement (group home , foster home, Psychiatric Residential Treatment Facility, alternative family living arrangement), or a family home / AFL(Alternative Family Living) or Therapeutic Foster Care to a living arrangement where the individual is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the individual's/legal guardian's/representative's name or a home owned by the individual. Covered transition services are: a. Security deposits that are required to obtain a lease on an apartment or home; b. Essential furnishings, such as furniture, window coverings, food preparation items, bed/bath linens; c. Moving expenses required to occupy and use a community domicile; d. Set-up fees or deposits for utility or service access, such as telephone, electricity, heating and water; e. Service necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Adult with IDD, TBI, SMI, or severe SUD who are moving from a living arrangement which they do not control into their own home in the community.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*

	a. Community Transition does not cover monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, VCR players and components and DVD players and components. Service and maintenance contracts and extended warranties are not covered. b. Community Transition has a limit $5,000 per individual during the 5-year period. c. Community Transition is available three months in advance of the individual's move. d. In situations where an individual lives with a roommate, Community Transition cannot duplicate items that are currently available. e. Community Transition includes the actual cost of services and does not cover provider overhead charges f. Community Transition expenses are furnished only to the extent that the beneficiary is unable to meet such expense or when the support cannot be obtained from other sources. The Community Transition Checklist is completed to document the items requested under this definition. The Checklist is submitted to the PHP by the agency that is providing the services.
☑	Medically needy *(specify limits):*
	Same as categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Specialized Vendor/ Suppliers	n/a	n/a	Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by PIHP

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

With the exception of Community Living and Support, (i) option services may not be furnished by parents, relatives who reside with the beneficiary, legally responsible individuals or legal guardians.

- For Community Living and Supports, up to 40 hours per week of service may be provided to an adult beneficiary by a parent or relative who resides with the beneficiary.
- The ISP must contain documentation that the beneficiary is in agreement 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 waiver service provision

The PHP or PIHP provides an increased level of monitoring for services delivered by relatives/legal guardians/other individuals who reside with the beneficiary. Services delivered by relatives/legal guardian/other individuals who reside with the beneficiary are monitored monthly. Care Managers conduct on-site monitoring and documentation review to ensure that payment is made only for services rendered and that the services are furnished in the best interest of the individual.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

X	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

N/A

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

x	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.
	☐	**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.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

x	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	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.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	**1a Service plans a) address assessed needs of 1915(i) participants.**
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need N= Care Plans/ISPs where beneficiaries indicate their Care Plan/ISP addresses their needs D=Total number of Care Plans/ISPs for (i) beneficiaries.
Discovery Activity *(Source of Data & sample size)*	ISP review 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
Frequency	Annually

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHP/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in reports to DHB. DHB may require a corrective action plan if the problems identified appear to require a change in the PHP/PIHP's processes for developing, implementing and monitoring service plans (or of their care management agencies).
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		1c1 Service plans document choice of services
Discovery		
	Discovery Evidence *(Performance Measure)*	Proportion of Tailored Plan or PIHP members using 1915(i) services reporting they have a choice of services. N= Care Plans/ISPs where beneficiaries indicate choice of service. D=Total number of Care Plans/ISPs for (i) beneficiaries.
	Discovery Activity *(Source of Data & sample size)*	Care Plan/ISP review 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHP/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in reports to DHB. DHB may require a corrective action plan if the problems identified appear to require a change in the PHP/PIHP's processes for developing, implementing and monitoring service plans (or of their care management agencies).
	Frequency *(of Analysis and*	Annually

	Aggregation)	

Requirement		1c2 Service plans document choice of providers
Discovery		
	Discovery Evidence *(Performance Measure)*	Proportion of Tailored Plan or PIHP members using 1915(i) services reporting they have a choice of providers. N= Care Plans/ISPs where beneficiaries indicate choice of service. D=Total number of Care Plans/ISPs for (i) beneficiaries.
	Discovery Activity *(Source of Data & sample size)*	ISP review 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		2aa Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery		
	Discovery Evidence *(Performance Measure)*	N = Number of evaluations for 1915 (i) applicants D = Number of 1915 (i) applicants
	Discovery	**Review of evaluations for 1915 (i) applicants**

	Activity *(Source of Data & sample size)*	**100%**
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**PHP or PIHP**
	Frequency	**Annually**
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	2ab Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery	
Discovery Evidence *(Performance Measure)*	N= Process for determining 1915 (i) eligibility is applied appropriately. D=Number of (i) applicants
Discovery Activity *(Source of Data & sample size)*	Review of evaluation 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
Frequency	Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	2ac the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	N= number of re-evaluations completed D= number of re-evaluations due
Discovery Activity *(Source of Data & sample size)*	Review of re-evaluations 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	3 Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	N = monitored providers that are compliant with 1915(i) requirements. D= number of monitored providers
Discovery Activity *(Source of Data & sample size)*	Post-payment reviews 100% of (i) providers with a post payment review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP-PIHP
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(l) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	N=Number of (i) providers of Supported Employment, Community Living and Support, and Individual and Transitional Support who meet HCBS setting requirements D= Number of (i) providers of Supported Employment, Community Living and Support, and Individual and Transitional Support
Discovery Activity *(Source of Data & sample size)*	HCBS assessment as outlined in STP. 100%

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP or PIHP
	Frequency	Semi-Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHPs/PIHPs will address, and correct problems identified on a case-by-case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan. The EQR annual technical report provides detailed information on the regulatory compliance of the PHP/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
	Frequency *(of Analysis and Aggregation)*	Semi-annually

Requirement		5. The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence *(Performance Measure)*	N- Reports due to CMS submitted on time D- Number of reports due to CMS
	Discovery Activity *(Source of Data & sample size)*	Reports to CMS 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHB
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DHB will submit reports timely to CMS. When reports are not submitted timely, DHB will determine the root cause and create a remediation plan.

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

	Requirement	6 The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	The proportion units paid by the PHP/PIHP for (i) option services that have been authorized in the care plan/ISP. Numerator: Number of units paid by the PHP/PIHP for (i) option services that have been authorized in the service plan. Denominator: Total number of units for (i) option services that have been paid.
	Discovery Activity *(Source of Data & sample size)*	Paid Claims/Service Plans 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP/PIHP
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHP/PIHP has the authority to require corrective action plans of each of their providers and recoup payments if they find that services are provided inappropriately – i.e., services are not provided in accordance with program requirements. The PHP/PIHP may require the providers to implement corrective action plans depending on the severity and nature of the problem. When significant problems are detected that may impact the health and safety of consumers, the PHP/PIHP reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the PHP/ PIHP.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	PHP/PIHP follow-up interventions were completed as required. Numerator: Number of Level 2 or 3 incident reports received by type of incident. Denominator: All level 2 or 3 incidents where Tailored Plan/LME-MCO follow-up intervention was required.
Discovery Activity *(Source of Data & sample size)*	PHP/PIHP NC Incident Reporting System (IRIS) or subsequent system 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP/PIHP State
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHP/PIHPs will analyze, and address problems identified and include the analysis in the report to DHB. In situations where providers are involved, the PHP/PIHPs may require provider corrective action plans or take other measures to ensure consumer protection. DHB will require corrective action plans of the PHP/PIHP if it is determined that appropriate action was not taken by the PHP/PIHP. Such corrective action plans are subject to DHB approval and monitored by DHB. DHB requires the PHP/PIHPs to contact DHB immediately about any issue that has or may have a significant negative impact on participant health and welfare. DHB and the PHP/PIHPs work together to resolve such issues as they occur.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	7 The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions. Numerator: Number of restrictive interventions conducted in accordance

		with state policy. Denominator: All restrictive interventions.
	Discovery Activity *(Source of Data & sample size)*	Incident Reports 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	PHP/PIHP NC Incident Reporting System (IRIS) or subsequent system
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PHP/PIHPs will analyze, and address problems identified and include the analysis in the report to DHB. In situations where providers are involved, the PHP/PIHPs may require provider corrective action plans or take other measures to ensure consumer protection. DHB will require corrective action plans of the PHP/PIHP if it is determined that appropriate action was not taken by the PHP/PIHP. Such corrective action plans are subject to DHB approval and monitored by DHB. DHB requires the PHP/PIHPs to contact DHB immediately about any issue that has or may have a significant negative impact on participant health and welfare. DHB and the PHP/PIHPs work together to resolve such issues as they occur.
	Frequency *(of Analysis and Aggregation)*	Quarterly

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

DHB will track and analyze data reported by PHP/PIHP to determine if system changes or contract changes are needed.

2. Roles and Responsibilities

DHB will work with PHP/PIHPs to implement any needed changes.

3. Frequency

At least annually, more frequently as needed.

4. Method for Evaluating Effectiveness of System Changes

Ongoing assessment of data

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

The State determines rates through a fee-for-service fee schedule methodology based on market data specific to the State of North Carolina. Similar services are currently offered by local management entities/managed care organizations (LME/MCOs) in the behavioral health managed care program under either 1915(b)(3) authority or through the 1915(c) Innovations waiver. Given these services are existing in the current market, the State relied on current reimbursement levels in the managed care program to inform the State's fee schedule. The State reviewed recent fee schedule rates across the LME/MCOs for the applicable services to assess reasonability and determine an appropriate market rate level.

☐	HCBS Case Management	
☐	HCBS Homemaker	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☐	HCBS Adult Day Health	
☑	HCBS Habilitation	
	Supported Employment (IDD) - rate same as (b)(3)/NC Innovations	
	Community Living and Support - rate same as (b)(3)/NC Innovations	
☑	HCBS Respite Care – **rate same as (b)(3)/NC Innovations**	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
x	Supported Employment for IDD and for MH/SUD (Individual Placement and Support (IPS)) - - rate same as (b)(3)	
X	Individual and Transitional Support - rate same as (b)(3) Individual Supports	
X	Community Transition – a rate is not set for this service. The cost of the service/item is paid.	

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*