STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

March 21, 2024

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 #2024-0018

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.

This State Plan Change will allow North Carolina to update the 1915(i) benefits by adding Tailored Plans as providing 1915(i) services upon Tailored Plan launch on July 1, 2024.

The proposed effective date of the SPA is July 01, 2024.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at (919) 538-3215.

Sincerely,

DocuSigned by:
Melanie Bush
B8DC650BFB454DA...

Melanie Bush for Jay Ludlam
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 1915(i) State Plan Option Services
- Supported Employment/Individual Placement Supports
- Community Living and Supports
- Individual and Transitional Supports
- Respite
- Community Transition

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*: *Completing this section does not authorize the provision of 1915(i) State Plan HCBS under these authorities. In order to operate concurrently with another Medicaid authority, the state must receive CMS approval via that Medicaid authority for the concurrent program which is separate and distinct from this 1915(i) authority.*

***Select one*:**

○	**Not applicable**
◉	**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.*
☒	**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:*
	The NC MH/IDD/SUD 1915(b) Waiver has been previously approved and provides managed care authority for North Carolina's PIHPs. Effective July 1, 2023, PIHPs will be authorized to offer and oversee delivery of the 1915(i)

		services for the populations that are delayed, exempt, or excluded from enrollment in integrated managed care plans authorized under the State's 1115 waiver. The 1915(b) wavier will be approved concurrently and operate concurrently with the 1915(i) SPA.		
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☒	**A program authorized under §1115 of the Act.** *Specify the program*:			
	The North Carolina Section 1115 Demonstration Project, which was approved in October 2018, authorizes managed care authority for Tailored Plans, which are specialized managed care organizations. 1915(i) services under this 1115 waiver authority will be provided by Tailored Plans and will be available statewide. The 1115 waiver must be approved at the same time or before the 1915(i) approval.			

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

●	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)*:		
	○	The Medical Assistance Unit *(name of unit)*:	Division of Health Benefits
	○	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.	
	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	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

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

Tailored Plan/PIHPs perform these activities under a contract with the State Medicaid agency.

1. Individual State Plan HCBS enrollment
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):*

For Tribal members who are exempt from enrollment in integrated Medicaid managed care, the State will allow the Cherokee Indian Hospital Authority (CIHA) to conduct assessment and care planning, although CIHA may also provide services to the members. CIHA is the only entity that has willing and qualified providers with experience and knowledge to provide services to individuals who share a common language or cultural background. Individuals providing care management and services will not work in the same unit. Individuals providing care management will not be:

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

Additionally, care managers may not supervise individuals providing 1915(i) services, and utilization managers and care managers may not be supervised by the same supervisor or manager.

Tribal members will be provided with information explaining that it is their choice to use CIHA and that independent care managers and service providers are available if they do not believe they need the common language/cultural background which only the CIHA can provide.

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	7/1/23	6/30/24	10,364
Year 2	7/1/24	6/30/25	
Year 3	7/1/25	6/30/26	
Year 4	7/1/26	6/30/27	
Year 5	7/1/27	6/30/28	

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

¡	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

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):*

The minimum qualifications for individuals performing evaluations/reevaluations are that these individuals meet North Carolina's definition of a Qualified Professional:

- An individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mental health, developmental disabilities and substance abuse services (mh/dd/sa) with the population served; or
- A graduate of a college or university with a Master's degree in a human service field and has one year of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time accumulated supervised experience in alcoholism and drug abuse counseling.

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 individual will be referred for assessment to an organization conducting care management—either the Tailored Plan/PIHP, a care management agency (behavioral health or I/DD provider certified by the State), or an AMH+ practice (primary care provider certified by the State) or, if a Tribal member, the CIHA. The individual must have a 1915(i) assessment completed prior to 1915(i) enrollment.

The State will conduct a brief evaluation to determine if an individual meets eligibility criteria (needs-based risk criteria, targeting criteria, and financial criteria, including confirming that the individual's income does not exceed 150% of the FPL). This evaluation will be at the initial request, and reevaluation will be done during the individual's birth month.

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):*

> Need for support in acquiring, maintaining, and retaining skills needed to live and work in the community, as evidenced by at least one functional deficit in ADLs, IADLs, social and/or work skills.

6. ☒ **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)
Need for support in acquiring, maintaining, and/or retaining skills needed to live and work in the community, as evidenced by at least one functional deficit in ADLs, IADLs, social and/or work skills.	**1.** Need for services, by physician's judgment, requiring: **A.** Supervision of a registered nurse (RN) or licensed practical nurse (LPN); and **B.** Other personnel working under the direct supervision of an RN or LPN. **2.** Observation and assessment of beneficiary needs by an RN or LPN. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that requires such concentrated monitoring. **3.** Restorative nursing measures once a beneficiary's medical condition becomes stable as noted in the treatment plan. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Restorative nursing measures are: **A.** A coordinated plan that assists an active beneficiary in achieving independence in activities of daily living, bathing, eating, toileting, dressing, transfer, and	In order to be Medicaid-certified at an ICF/IID level of care, a beneficiary shall meet the following criteria: **1.** Require active treatment necessitating the ICF/IID level of care; and **2.** 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. **i.** 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. **ii.** 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:	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.

	ambulation; **B.** Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows; **C.** Ambulation and gait training with or without assistive devices; or **D.** Assistance with or supervision of the transfer, so the beneficiary would not necessarily require skilled nursing care. **4.** Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan. **5.** Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment, such as the use of dietary supplements, therapeutic diets, and frequent recording of the participant's nutritional status. **6.** Administration or control of medication as required by State law to be the exclusive responsibility of the licensed nurse: **A.** Drugs requiring intravenous, hypodermoclysis, or nasogastric tube administration; **B.** The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or **C.** Frequent injections requiring nursing skills or professional judgment. **7.** Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN: **A.** Primary source of nutrition by daily bolus or continuous feedings; **B.** Medications administered through the tube; **C.** When beneficiary on dysphagia diet, pureed diet, or soft diet with thickening liquids; and **D.** Tube with flushes. **8.** Respiratory therapy: oxygen as a temporary or intermittent therapy, or for a beneficiary who receives oxygen continuously as a component to a stable treatment plan: **A.** Nebulizer usage; **B.** Nasopharyngeal or tracheal suctioning; **C.** Oral suctioning; and **D.** Pulse oximetry. **9.** Isolation when medically necessary as a limited measure because of a contagious or infectious disease. **10.** Wound care of decubitus ulcers	**i.** Cerebral palsy or 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 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 nonverbally); **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	"Occasional" is defined as less than four times per week. The person 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 four 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 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 LOC 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 LOC.

	or open areas. **11.** Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan. **12.** HCBS Nursing Facility LOC may be established if having two (2) or more conditions in Category I OR one (1) or more conditions from both Categories I and II below. **1.** Category I (two or more, or at least one in combination with one from Category II): **A.** Ancillary therapies: supervision of participant's performance of procedures taught by a physical, occupational, or speech therapist, consisting of care of braces or prostheses and general care of plaster casts; **B.** Chronic recurrent medical problems that require daily observation by licensed personnel or other personnel for prevention and treatment; **C.** Blindness; **D.** Injections, requiring administration or professional judgment by an RN or LPN, or a trained personal assistant; **E.** Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control: **i.** Vision, dexterity, and cognitive deficiencies; or **ii.** Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous (IV) or intramuscular (IM) or oral intervention; **F.** Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction as prescribed by a primary care physician; **G.** Frequent falls due to physical disability or medical diagnosis; **H.** Behavioral symptoms due to cognitive impairment and depressive disorders such as: **i.** Wandering due to cognitive impairments; **ii.** Verbal disruptiveness; **iii.** Physical aggression; **iv.** Verbal aggression or physical abusiveness; or **v.** Inappropriate behavior (when it can be properly	assistance).	

	managed in the community setting). **2.** Category II: (One or more conditions from both Category I and II) **A.** Need for teaching and counseling related to a disease process, disability, diet, or medication. **B.** Adaptive programs: re-training the beneficiary to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the beneficiary's participation in the program and document the beneficiary's progress. **C.** Factors to consider along with the beneficiary's medical needs are psychosocial determinants of health such as: **i.** Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders and progress notes, or by nursing or therapy notes); **ii.** Age; **iii.** Length of stay in current placement; **iv.** Location and condition of spouse or primary caregiver; **v.** Proximity and availability of social support; or **vi.** Effect of transfer on individual, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry about transfer).		

*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)*):

The target groups will be beneficiaries ages 3 and older with I/DD, TBI, SMI (including SPMI), SED, or severe SUD.

Individuals enrolled in the 1915(c) Innovations, or TBI waiver will not be included in 1915(i) target groups because they will have equivalent benefits provided through the 1915(c) Innovations

or TBI waiver. Individuals on the waitlist for the 1915(c) Innovations or TBI waiver will be eligible to obtain 1915(i) services if they are part of a target group and meet the functional limitation and eligibility requirements.

☐ **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):

(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):	
	◉	**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.)

Beneficiaries may obtain 1915(i) services in the following settings: private homes, the community, group homes, integrated employment sites, or micro-enterprise. All settings where the 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 integrated settings. These HCBS rules will be applied to all individuals in residential supports and supported employment/individual placement support 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 potentially impact are:

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

Please note that 1915(i) providers must comply to provide 1915(i) services.

Services provided to individuals in private homes are assumed to meet HCBS requirements. Individuals residing in their own or family homes will be monitored to ensure that they are afforded the same rights as those in other settings. The State will monitor this through the use of the Quarterly HCBS monitoring tool.

Providers must complete a self-assessment, which is reviewed by the Tailored Plan/PIHP for compliance. The Tailored Plan/PIHP may review the assessment using at least one of the following strategies to validate the self-assessment: face-to-face care management review and completion of the Care Management tool; HCBS Quarterly Monitoring Tab, which is submitted to the Tailored Plan/PIHP; quality management/provider network team review; desk review of provider policies/procedures, Care Plans/ISPs, care management monitoring tools and any applicable My Individual Experience (MIE) Surveys; Intense On-site Review—which may be triggered by discrepancy in policies presented, provider self-assessment, and the care management monitoring tool; and telehealth visit with two-way, real-time, interactive audio/video.

DHHS also validates a sample of Tailored Plan/PIHP provider self-assessments via a desk review.

An MIE Survey is an assessment that is completed by the individual receiving HCBS. This survey is mirrored against the provider assessment; however, it is in a format that is easily understood, in person-first language, and contains graphics. The survey asks for the provider/site where individuals receive services so that the information received can inform the assessment of the provider/site. This survey is sent to a sample of individuals in each service. A series of "threshold" questions have been identified in each survey. If these questions are all answered in a manner that is noncompliant by HCBS standards, the survey will be flagged, and the DHHS HCBS internal team and Tailored Plan/PIHP staff will be alerted to follow up. The DHHS HCBS internal team has provided a standardized series of follow-up questions to be used in the follow-up process if the survey is flagged, and a template for reporting findings and follow-up actions has been provided to the Tailored Plan/PIHP staff.

If the MIE results are inconsistent with the provider's self-assessment results, the provider will be required to develop a Plan of Action. An analysis of surveys and actions taken will be submitted to the DHHS HCBS internal team quarterly.

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):*

Care managers based at State-certified AMH+ primary care practices, State-certified CMAs, Tailored Plans and PIHPs will be responsible for completing the assessment.

Care managers must meet North Carolina's definition of a Qualified Professional:

- An individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mental health, developmental disabilities and substance abuse services (mh/dd/sa) with the population served; or
- A graduate of a college or university with a Master's degree in a human service field and has one year of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time accumulated supervised experience in alcoholism and drug abuse counseling.

The State will work with the Eastern Band of the Cherokee Indians to allow CIHA to conduct the assessment for Tribal members. The Tribal assessors will have the same qualifications as other independent assessors. The CIHA will have oversight of the Tribal assessors, and the State will do a sampling of the assessments to ensure that they meet the requirements. Tribal members will have a choice of who completes the assessment. Tribal assessment will only be

available to Tribal members. Tribal members may choose care management and services provided by Tribal or external providers.

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):*

North Carolina is referring to the person-centered service plan as the Care Plan for individuals with a behavioral health need and the Individual Support Plan (ISP) for individuals with an I/DD or TBI. Care managers based at State-certified AMH+, State-certified CMAs, Tailored Plans, PIHPs and if a Tribal member, the CIHA will be responsible for Care Plan and ISP development.

Care managers must meet North Carolina's definition of a Qualified Professional:

- An individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mental health, developmental disabilities and substance abuse services (mh/dd/sa) with the population served; or
- A graduate of a college or university with a Masters degree in a human service field and has one year of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time accumulated supervised experience in alcoholism and drug abuse counseling.

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 (for people with behavioral health needs) or Individual Support Plan (ISP) (for people with I/DD and TBI needs) 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, with support from the care manager. 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.

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 Tailored Plans/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 1915(i) services. Provider choice must be attested by the beneficiary in the Care Plan or ISP.

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 Individual Support Plan (ISP) or Care Plan is submitted by the care manager to the Tailored Plan or PIHP in which the beneficiary is enrolled. The ISP or Care Plan is reviewed and approved by the beneficiary's Tailored Plan/PIHP. The State will work with the External Quality Review (EQR) to sample plans to ensure that they meet the requirements for person-centered plans.

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/Individual Placement Supports
Service Definition (Scope):	

The intent of Supported Employment/Individual Placement Supports is to assist individuals in developing/regaining 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. Supported Employment includes Individual Placement Supports which is an evidenced based practice of Supported Employment. Please note that any exclusions for Supported Employment would apply to Individual Placement Supports.

Beneficiaries with a youth employment certificate will be evaluated on a case-by-case basis.

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.

Additional needs-based criteria for receiving the service, if applicable *(specify):*
The participant who expresses the desire to work and has an established pattern of unemployment, underemployment, or sporadic employment; or needs assistance with achieving educational goals which are necessary to meet employment goals; and requires assistance in obtaining or maintaining employment in addition to what is typically available from the employer because of functional limitations 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):*

	Exclusions: federal financial participation (FFP) cannot 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 Education Act, Supported Employment does not include transportation to or from school settings. This includes transportation to or from the individual's home, the 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 nondisabled individuals or in 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 services 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. Services may not occur in segregated settings or sheltered workshops. The following activities are not covered under Supported Employment/Individual Placement Supports: a) Services provided to teach academic subjects or as a substitute for educational personnel, including a teacher, teacher's aide, or 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) Transitional employment; f) Group employment searches or classes; g) Habilitative services for the individual to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings; h) Non-employment-related transportation for the individual or family; i) Any services provided to family, friends, or natural supports of the individual receiving Supported Employment/Individual Placement Supports to address problems not directly related to the individual's issues and not listed on the ISP, Care Plan, and/or Employment Plan; j) Clinical and administrative supervision of staff; k) Time spent in meetings where the eligible individual is not present; and l) For the IPS model for MH and SUD, group employment/work crews. Additionally, if an eligible individual is receiving services from both DHB and the Division of Vocational Rehabilitation Services (DVR), Medicaid funds will only reimburse for services not covered by DVR or in an employment milestone funded by DVR.
☒	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, which are defined as providers who have a contract with the Tailored Plan/PIHP, are accredited within a year of starting services, and are enrolled with NC Medicaid.	N/A	N/A	• Meet provider qualification policies, procedures, and standards established by DHB, and be enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and State requirements, including DHHS statutes, rules, policies, communication bulletins, and other published instructions; • Obtain national accreditation within one year of enrollment (COA, CARF, CQL, or Joint Commission)
Additional requirements for IPS providers			Adherence to the fidelity model.

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 Supports

Service Definition (Scope)*:*

This 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. This service 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. This service 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):*

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):*

a. This service may be provided to Adult @ 28 hours/week; Child @ 15 hours/week (when in school) or 28 hours/week (when not in school)

b. For individuals who are eligible for educational services under the Individuals with Disability Education 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.

c. This service may not be provided during the same time as any other direct support Medicaid service.

☒ 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, which are defined as providers who have a contract with the Tailored Plan/PIHP, are	N/A	N/A	• Meet provider qualification policies, procedures, and standards established by DHB, and be enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and State requirements, including DHHS statutes, rules, policies,

accredited within a year of starting services, and are enrolled with NC Medicaid.			communication bulletins, and other published instructions; • Obtain 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 Supports

Service Definition (Scope)*:*

This service provides support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in employment, education, community life, maintaining housing, and residing successfully in the community. A paraprofessional assists the person in learning new skills and/or supports the person in activities that are individualized and aligned with the person's preferences. The intended outcome of the service is to increase or maintain the person's life skills to empower the person, increase self-determination, and enhance the person's opportunity to have full membership in his/her community. Areas of support consist of assistance in monitoring a health condition, nutrition, or physical condition; incidental supervision; daily living skills; community participation; interpersonal skills; and support to maintain abstinence through the development of relapse prevention skills.

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

At least one deficit in an ADL or 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 solely for the convenience of the caregiver of the beneficiary receiving the services are not covered. This service 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. **b.** For individuals who are eligible for educational services under the Individuals with Disability Education Act, Individual and Transitional Supports does not include transportation to/from school settings. This includes transportation to/from the beneficiary's home, the 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. **c.** This service may not be provided during the same time as any other direct support Medicaid service. **d.** This service may not be provided during the same authorization period as Assertive Community Treatment or Community Support Team. **e.** This service may not be provided to children ages 16 to 21 who reside in a Medicaid-funded group residential treatment facility. **f.** This service may not be provided by family members. **g.** This service may be provided up to 60 hours per month for rehabilitation.
☒	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, which are defined as providers who have a contract with the Tailored Plan/PIHP, are accredited within a year of starting services, and are enrolled with NC Medicaid.	N/A	N/A	• Meet provider qualification policies, procedures, and standards established by DHB, and be enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and State requirements, including DHHS statutes, rules, policies, communication bulletins, and other published instructions; • Obtain 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 are to 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 primary caregiver(s) of individuals who reside in Licensed and Unlicensed AFLs, as well as Therapeutic Foster Care. This service enables the primary caregiver to meet or participate in planned or emergency events and to have planned time for himself/herself and/or family members. This service also enables the individual to receive periodic support and relief from the primary caregiver(s) of his/her choice. Respite may be utilized during school hours for sickness or injury. Respite may include in-home and out-of-home services, inclusive of overnight, weekend care, or emergency care (family-emergency-based, not to include an 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):*

To be eligible for this service, an individual must:

- Require assistance with at least one of the following areas of major life activity, as appropriate to the person's age: receptive and expressive language, learning, self-care, mobility, self-direction, or capacity for independent living; **or**
- Not have the ability to care for themselves in the absence of a primary caregiver and have needs that exceed that of a child without behavioral health concerns/developmental disabilities that could have care provided by a traditional babysitter or day care.

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.** FFP will not be claimed for the cost of room and board except when provided as part of Respite care furnished in an institution. **f.** For individuals who are eligible for educational services under the Individuals with Disability Education Act, Respite does not include transportation to/from school settings. This includes transportation to/from the beneficiary's home, the 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. **i.** Respite is a short-term service. **j.** Providers of residential services (AFLs and Therapeutic Foster Care) may not be paid for the same times that an individual is receiving Respite care. **k.** Members enrolled in the CAP/C or CAP/DA waiver are not eligible for Respite services in the 1915(i).
☑	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, which are defined as providers who have a contract with the Tailored Plan/PIHP, are accredited within a year of starting services, and are enrolled with NC Medicaid.	NC G.S. 122 C (specific to facility Respite providers)	N/A	• Meet provider qualification policies, procedures, and standards established by DHB, and be enrolled in NC Medicaid; • Fulfill the requirements of 10A NCAC 27G; • Comply with all applicable federal and State requirements, including the DHHS statutes, rules, policies, communication bulletins, and other published instructions; • Obtain 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 setup to facilitate the individual's transition from a State Developmental Center (ICF-IID), community ICF-IID, nursing facility,, or another provider-operated/controlled settings (adult care home, psychiatric residential treatment facility, foster home, AFL (Alternative Family Living), group home) to a living arrangement where the individual is directly responsible for his or her own living expenses. The state cannot claim FFP for these services until the individual is determined eligible for and enrolled into the 1915(i) State Plan benefit. These are one-time, non-reoccurring expenses. Individuals transitioning from an institutional setting may receive transitional assistance to any home and community-based setting that meets the HCBS settings requirements.

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. Setup fees or deposits for utility or service access, such as telephone, electricity, heating and water;
e. Services 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):*

Individuals who are moving from a living arrangement that they do not control into their own home in the community and need initial setup expenses/items.

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 expenses; food expenses; regular utility charges; 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 of $5,000 per individual during the five-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 expenses 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 Tailored Plan/PIHP by the agency that is providing the services. **g.** Food expenses are prohibited. **h.** Members ages 21 through 64 transitioning from an IMD are not eligible for Community Transition services in the 1915(i). **i.** Members enrolled in the CAP/C or CAP/DA wavier are not eligible for Community Transition services in the 1915(i).
☑	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 Vendors/Suppliers	N/A	N/A	Meets applicable State and local regulations for the type of service that the provider/supplier is providing as approved by Tailored Plan/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):*
Vendors/Suppliers	Tailored Plan/PIHP	At the time of first use

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):*

Community Living and Support services may be provided to an adult beneficiary by a parent or relative who resides with the beneficiary.

Relatives, legally responsible individuals, and legal guardians will only be paid to provide services that are for extraordinary care (exceeds the range of activities that they would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age).

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 service provision.

The Tailored Plan/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 guardians/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. (S*elect one):*

◉	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.

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):*

◉	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):*

◉	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 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 beneficiaries using 1915(i) services
Discovery Activity *(Source of Data & sample size)*	ISP review 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Tailored Plan or PIHP
Frequency	Annually

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/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 Tailored Plan/PIHPs' processes for developing, implementing, and monitoring Care Plans/ISPs, including processes implemented by their contracted advanced medical home plus (AMH+) practices (primary care providers certified by the State) or Care Management Agencies (CMAs) (behavioral health or I/DD providers certified by the State.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**1c1. Service plans document choice of services.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number of 1915(i) participants reporting they have a choice of services compared with the number of 1915(i) participants N=Care Plans/ISPs where beneficiaries indicate choice of service D=Total number of Care Plans/ISPs for beneficiaries using 1915(i) services
Discovery Activity *(Source of Data & sample size)*	Care Plan/ISP review 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Tailored Plan or PIHP
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/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 Tailored Plan/PIHPs' processes for developing, implementing, and monitoring Care Plans/ISPs, including processes implemented by their contracted AMH+ practices or CMAs.
Frequency *(of Analysis and*	Annually

Aggregation)	

Requirement	**1c2. Service plans document choice of providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number of 1915(i) participants reporting they have a choice of providers compared with the number of 1915(i) participants N=Care Plans/ISPs where beneficiaries indicate choice of service D=Total number of Care Plans/ISPs for beneficiaries using 1915(i) services
Discovery Activity *(Source of Data & sample size)*	ISP review 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Tailored Plan or PIHP
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plans/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 Tailored Plan/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**2aa. Eligibility Requirements: an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants who are assessed for 1915(i) option services.**
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)*	SMA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will address and correct problems identified on a case-by-case basis and include that information in reporting to CMS.
	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=Number of 1915(i) evaluations where eligibility is applied appropriately. D=Number of 1915(i) e evaluated
Discovery Activity *(Source of Data & sample size)*	Review of evaluation 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Annually
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will address and correct problems identified on a case-by-case basis and include that information in reporting to CMS.
	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 reevaluations completed D=Number of reevaluations due
	Discovery Activity *(Source of Data & sample size)*	Review of reevaluations 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will address and correct problems identified on a case-by-case basis and include that information in reporting to CMS.
	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)*	Tailored Plans or PIHPs
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/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 Tailored Plan/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 1915(i) providers of Supported Employment/Individual Placement Supports, Individual and Transitional Supports, and Community Living and Support who meet HCBS setting requirements D=Number of 1915(i) providers of Supported Employment/Individual Placement Supports, Individual and Transitional Supports, and Community Living and Support Supported employment/Individual Placement Supports, residential sites, and private living arrangements require compliance with the HCBS Final Rule. Care managers will monitor for compliance.

	Discovery Activity *(Source of Data & sample size)*	HCBS assessment as outlined in HCBS Transition Plan 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Tailored Plan or PIHP
	Frequency	Semiannually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/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 Tailored Plan/PIHPs, as well as results of performance improvement projects (PIPs) and performance measures (PMs).
	Frequency *(of Analysis and Aggregation)*	Semiannually

Requirement	**5. The SMA retains authority and responsibility for program operations and oversight.**
Discovery	
Discovery Evidence *(Performance Measure)*	Numerator: Number of Tailored Plan/PIHP reports reviewed within 10 business days by DHB annually Denominator: Total number of Tailored Plan/PIHP reports received by DHB annually 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 remediation activities; required timeframes for remediation)*	DHB will submit reports timely to CMS. When reports are not submitted timely, DHB will determine the root cause and create a remediation plan.
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 of units paid by the Tailored Plan/PIHPs for 1915(i) services that have been authorized in the Care Plan/ISP Numerator: Number of units paid by the Tailored Plan/PIHPs for 1915(i) services that have been authorized in the service plan Denominator: Total number of units for 1915(i) 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)*	Tailored Plan or PIHP
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/PIHP has the authority to require corrective action plans from 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 Tailored Plan/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 Tailored Plan/PIHP reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the Tailored Plan/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)*	Tailored Plan/PIHP follow-up interventions were completed as required. Numerator: Number of level 2 and 3 incident reports received by type of incident Denominator: All level 2 and 3 incidents where Tailored Plan/PIHP follow-up intervention was required
Discovery Activity *(Source of Data & sample size)*	Tailored Plan/PIHP NC Incident Reporting Improvement System (IRIS) or subsequent system 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Tailored Plan/PIHP State
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/PIHPs will analyze and address problems identified and include the analysis in the report to DHB. In situations where providers are involved, the Tailored Plan/PIHPs may require provider corrective action plans or take other measures to ensure consumer protection. DHB will require corrective action plans of the Tailored Plan/PIHP if it is determined that appropriate action was not taken by the Tailored Plan/PIHP. Such corrective action plans are subject to DHB approval and monitored by DHB. DHB requires the Tailored Plan/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 Tailored Plan/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)*	Tailored Plan or PIHP NC Incident Reporting Improvement System (IRIS) or subsequent system
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Tailored Plan/PIHPs will analyze and address problems identified and include the analysis in the report to DHB. In situations where providers are involved, the Tailored Plan/PIHPs may require provider corrective action plans or take other measures to ensure consumer protection. DHB will require corrective action plans of the Tailored Plan/PIHPs if it is determined that appropriate action was not taken by the Tailored Plan/PIHPs. Such corrective action plans are subject to DHB approval and monitored by DHB. DHB requires the Tailored Plan/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 Tailored Plan/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 Tailored Plan/PIHPs to determine if system changes or contract changes are needed.

2. **Roles and Responsibilities**

DHB will work with Tailored Plan/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