North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

January 31, 2013

The Honorable Louis Pate, Chair
Appropriations on Health and
Human Services
Room 1028, Legislative Building
Raleigh, North Carolina 27601-2808

The Honorable Ralph Hise, Chair
Appropriations on Health and
Human Services
Room 1026, Legislative Building
Raleigh, North Carolina 27601-2808

Dear Senators Pate and Hise:

Session Law 2012-142, Section 10.23A(b) established the Blue Ribbon Commission on Transitions to Community Living to examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities. The Commission was charged to develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence.

The Blue Ribbon Commission issued its final report on December 19, 2012, which included several directives for the Department of Health and Human Services (DHHS). Recommendation 4 directed DHHS to explore a supplement to be paid on behalf of an Adult Care Home Resident. DHHS, in collaboration with the Division of Aging and Adult Services and the Division of Health Service Regulation, distributed a memo to stakeholders, County Division of Social Services directors, behavioral health managed care entities, and licensed residential providers on January 28, 2013. This letter outlined the conditions which families and responsible persons may be charged for services.

Recommendation 7 directed DHHS to prepare a Medicaid "I" option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Working with stakeholders, DMA drafted a 1915(i) option State Plan Amendment that includes a proposed service called 'Individualized Support.' Individualized Support consists of habilitation services, i.e. training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes will focus on allowing the individual to participate in home life activities and reside as independently as possible in the community.

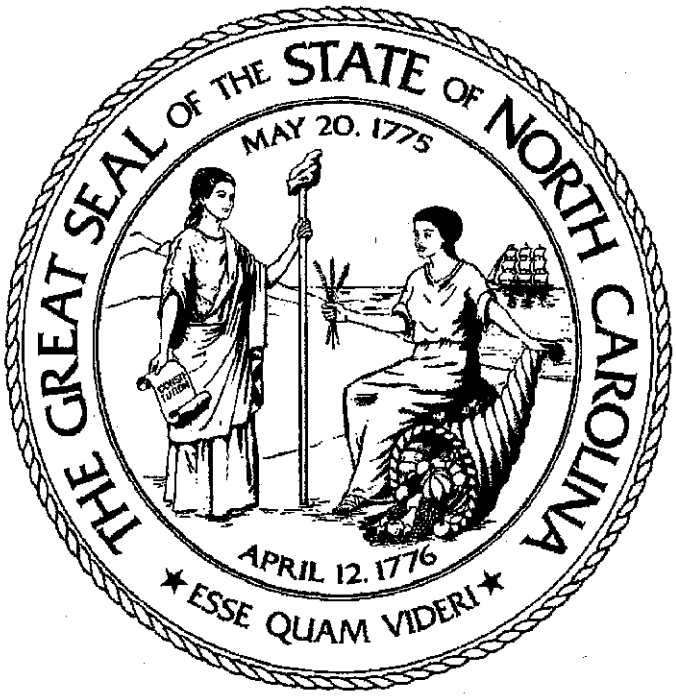
On behalf of the Department, I respectfully submit this report. If you have further questions or need additional information, please contact Carol Steckel, Medicaid Director, at 919-855-4100.

Sincerely,

Aldona Wos, M.D.
Secretary

cc: Carol Steckel
Jim Slate
Matthew McKillip
Pam Kilpatrick
Susan Morgan
Patricia Porter
Legislative Library (one hard copy)

DHHS STATUS REPORTS
BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING RECOMMENDATIONS
S.L. 2012-142, Section 10.23A



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

January 2013

SUMMARY

This report will provide Department of Health and Human Services (DHHS) status updates on recommendations 4 and 7 from the Blue Ribbon Commission on Transitions to Community Living.

BLUE RIBBON SUBCOMMITTEE RECOMMENDATION 4: EXPLORE A SUPPLEMENT TO BE PAID ON BEHALF OF AN ACH RESIDENT

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

DHHS, in collaboration with the Division of Aging and Adult Services and the Division of Health Service Regulations, distributed a memo to stakeholders, County DSS Directors, Behavioral Health LME/MCOs and licensed 131D and 122C residential providers on January 28, 2013. This letter outlines the conditions which families and responsible persons may be charged for services.

BLUE RIBBON SUBCOMMITTEE RECOMMENDATION 7: HABILITATION SERVICES FOR IDD ADULTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to prepare a Medicaid "I" option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this "I" option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This Medicaid "I" option should be incorporated into the support needs process and the management and capitation of the LME/MCOs.

Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013. The Department shall not take further action on the application until there is approval by the NC General Assembly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

1915(i) Option Stakeholder Workgroup

Session Law 2011-264 House Bill 916, Section 1.(f) directed [that]:

> *By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).*

In response to SL 2011-264, a stakeholder group was formed to explore the development of a 1915(i) option habilitative benefit for adults with Intellectual or Developmental Disabilities (IDD). The workgroup met during SFY 2012 to explore habilitative service options for individuals not otherwise eligible for Medicaid services under a 1915(c) waiver or in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IIDD). The group's charge was to develop a focused service that could prove to be both a cost-neutral and meaningful benefit to individuals with intellectual and developmental disabilities (IDD). The workgroup included members from the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the North Carolina Provider Council, the Autism Society, the Arc of North Carolina, Rubicon (ICF-MR providers who provide home and community based waiver services), the Council on Developmental Disabilities, and First in Families (representing families and consumers). This response reflects the recommendations of that stakeholder workgroup.

What is the Medicaid 1915(i) Option?

The 1915(i) option is outlined in Section 1915(i) of the federal Social Security Act. It allows for states to offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. The State is able to target the HCBS benefit to one or more specific populations, such as individuals with IDD, and establish additional needs based criteria for eligibility. The State Medicaid agency must submit a State Plan amendment (SPA) to CMS for review and approval to establish a 1915(i) HCBS benefit.

The 1915 (i) option must be developed with federal guidelines which include:

- establishing a process to ensure that assessments/evaluations are independent and unbiased;
- ensuring that the benefit is available to all eligible individuals within the State;
- ensuring that measures will be taken to protect the health and welfare of participants;
- providing adequate and reasonable provider standards to meet the needs of the target population;
- ensuring that services are provided in accordance with a plan of care; and
- establishing a quality assurance, monitoring and improvement strategy for the benefit.

Eligible Medicaid beneficiaries may access this proposed (i) option benefit if they are living in a private residence or a residential setting. The (i) option benefit cannot be targeted by living arrangement except that any living arrangement must meet CMS-approved home and community living standards.

Proposed 1915(i) Option Service in North Carolina

The stakeholder workgroup has proposed a service called 'Individualized Support.' Individualized Support consists of habilitation, i.e. training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes focus on allowing the individual to participate in home life activities and reside as independently as possible in the community. This service includes assistance in community activities when the individual is dependent on others to ensure health and safety. Individualized Support also provides assistance with ADLs and instrumental activities of daily living (IADLs). IADLs are meal preparation, medication assistance, and basic home management tasks that are directly related to the qualifying ADLs and essential to the individual's care at home.

Proposed Target Population for the 1915(i) Option

The proposed target population for the 1915(i) option is Medicaid beneficiaries age 18 or older with a documented IDD diagnosis who do not meet eligibility criteria for treatment in an Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF-IID). A physician must attest that the individual's diagnosis limits the individual's ability to

independently acquire, improve, and retain skills needed for the individual to participate in home life or community activities.

Individuals must have physician-documented need for caregiver availability and an unmet need for hands-on assistance with two (2) activities of daily living (ADLs) and set up/supervision assistance including cueing/prompting with an expectation of skill building (habilitation) with one ADL. ADLs that are assessed are bathing, dressing, mobility, toileting, and eating.

Independent Assessment for 1915(i) Option Services

The amount of service provided to the individual will be based on an assessment conducted by an independent entity to determine the individual's support needs. Performance is rated as: totally independent, requiring cueing or supervision, requiring limited assistance, requiring extensive assistance or totally dependent. Individuals are then assigned a number of service increments according to their assessed needs.

Evaluations and reevaluations of individuals for 1915(i) eligibility will be performed by vendors under contract to the Division of Medical Assistance (DMA). DMA has the potential to leverage a current vendor contract and assessment process. DMA currently has a contract with the Carolinas Center for Medical Excellence (CCME) to conduct evaluations. The vendor(s) conducting the evaluations and reevaluations will not under any circumstances be providers of 1915(i) services. The long term goal is to move this assessment process under the MCO/LMEs behavioral health as part of care coordination/utilization review.

Projected Costs of the 1915(i) Option

Cost estimates are based on the rate for a comparable 100 percent state-funded service (Personal Assistance) and an estimate of individuals who could access this service. An estimate of the number of individuals who could potentially qualify for this service was determined by looking at two data sources: 1) individuals living in licensed facilities with IDD who do not meet criteria for personal care services (PCS) under the new PCS assessment process through Carolina's Center for Medical Excellence (CCME), and 2) individuals with IDD who are living in private residences who do not meet criteria for PCS services as determined by the utilization review/assessment contractor (CCME).

According to data collected during the PCS assessment process through December 2012, 21 percent of individuals with IDD living in licensed facilities did not meet the eligibility criteria for PCS. This represents 4153 individuals. It is important to note that not all individuals in these settings will meet eligibility criteria under the proposed 1915(i) option. It is also likely that some of these licensed facilities will not meet CMS-approved home and community characteristics. In those cases, individuals living in those facilities will not be eligible for the new 1915(i) option benefit. A total of 157 individuals with IDD in private homes did not meet criteria for PCS in 2012, according to data reported by CCME.

The Individualized Supports service rate was modeled off of the State-funded service Personal Assistance. This service provides both habilitation and assistance with ADLs for individuals with IDD. The rate of this comparable service is $4.46 per 15 minute unit ($17.84 per hour). This rate is higher than State Plan PCS because staff must have additional training to provide habilitation or training to the individuals and due to documentation requirements.

Finally, the proposed costs will need to be determined based on estimates of service utilization—in this case, the average monthly units of PCS delivered to individuals with IDD in licensed facilities. DMA determined that on average, individuals who receive PCS in facilities access 50.5 hours or 202 units per month, and individuals who receive PCS in private home access 37.5 or 150 units per month. It is important to note that these averages are across diagnostic groups and are not specific to individuals with IDD.

Maintaining individuals in their current average level of service at 186 units (46.5 hours) per month would result in the following service costs from SFY 2013 through SFY 2017:

Option 1

Additional Costs/(Savings)	$2,840,430	$2,931,608	$3,025,712	$3,122,838
Federal Share	$1,866,447	$1,926,359	$1,988,196	$2,052,017
State Share	$973,983	$1,005,248	$1,037,517	$1,070,821

In order to meet cost neutrality or produce cost savings, DMA may need to set a lower benefit limit or further restrict the eligibility group. For example, restricting the benefit limit to 124 units (31 hours per month) would result in the following cost savings from SFY 2013 through SFY 2017:

Option 2

Additional Costs/(Savings)	($11,937,428)	($12,320,620)	($12,716,112)	($13,124,299)
Federal Share	($7,844,084)	($8,095,879)	($8,355,757)	($8,623,977)
State Share	($4,093,344)	($4,224,740)	($4,360,355)	($4,500,322)

A more thorough and comprehensive fiscal note must be completed after the eligibility parameters and service definition for Individualized Supports is finalized through discussions with the Centers for Medicare and Medicaid (CMS).

On-going Development of the 1915(i) Option

In order to begin a more robust development process, the General Assembly must direct DMA to develop and submit a SPA for this new habilitative benefit. Since a draft has already been submitted to CMS (see attached), DMA anticipates receiving technical assistance from CMS as we continue to refine the target population, the service parameters, and the on-going assessment strategy for this proposed new benefit. DMA will rely on

CMS assistance and stakeholder input to further refine the service description and target population.

Once the final service definition is determined, DMA will develop a Clinical Coverage Policy for the benefit. The policy will require approval by the Physician's Advisory Group (PAG) and may require changes to State Administrative Rule. As part of the policy development and State Plan approval process, DMA will need to determine the final rate for this service.

In order to assure appropriate utilization management and qualitative oversight of this service, DMA will amend the 1915(b) waiver to delegate management and oversight of this benefit to the Local Management Entity-Managed Care Organizations (LME-MCOs). CMS must approve the incorporation of the 1915(i) option into the 1915(b) waiver and must approve any new capitation rates.

A comprehensive fiscal note will be completed once the State Plan amendment is finalized to include projected service dollars, administrative costs for training, administration costs for the assessment process, costs for any MMIS system changes, and increased capitation payments to the LME-MCOs.

Analysis of I-Option Program Costs for Adults with IDD (186 units)

	SFY 2013	SFY 2014	SFY 2015	SFY2016	SFY2017
Existing Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	202	202	202	202	202
Total ACH	$19,529,732	$40,360,143	$41,655,704	$42,992,852	$44,372,923
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	150	150	150	150	150
Total In-Home Adults	$548,244	$1,133,001	$1,169,370	$1,206,907	$1,245,649
Total Existing Program Costs	$20,077,976	$41,493,145	$42,825,074	$44,199,759	$45,618,572
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$13,153,082*	*$27,265,145*	*$28,140,356*	*$29,043,662*	*$29,975,963*
State Share	*$6,924,894*	*$14,227,999*	*$14,684,718*	*$15,156,097*	*$15,642,608*
I-Option Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	186	186	186	186	186
Total ACH	$0.00	$42,718,639	$44,089,907	$45,505,194	$46,965,910
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	186	186	186	186	186
Total In-Home Adults	$0.00	$1,614,935	$1,666,775	$1,720,278	$1,775,499
Total I-Option Program Costs	$0	$44,333,574	$45,756,682	$47,225,472	$48,741,409
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$0*	*$29,131,592*	*$30,066,716*	*$31,031,857*	*$32,027,980*
State Share	*$0*	*$15,201,983*	*$15,689,966*	*$16,193,614*	*$16,713,429*
Additional Costs/(Savings)	*0*	***$2,840,430***	***$2,931,608***	***$3,025,712***	***$3,122,838***
Federal Share	*0*	***$1,866,447***	***$1,926,359***	***$1,988,196***	***$2,052,017***
State Share	*0*	***$973,983***	***$1,005,248***	***$1,037,517***	***$1,070,821***

Change in Eligibility

SFY 2014	SFY 2015	SFY 2016	SFY 2017
3.33%	*3.21%*	*3.21%*	*3.21%*

$3.88 *Cost/Unit*

$4.46 *Cost/Unit*

Notes:

1. *I-Option Program effective date is 07/01/2013*
2. *SFY2013 represents 6 months of existing program costs; additional cost/savings not applicable*
3. *Average Units/Month and Cost/Unit remain unchanged*

Analysis of I-Option Program Costs for Adults with IDD (124 units)

	SFY 2013	SFY 2014	SFY 2015	SFY2016	SFY2017
Existing Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	202	202	202	202	202
Total ACH	$19,529,732	$40,360,143	$41,655,704	$42,992,852	$44,372,923
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	150	150	150	150	150
Total In-Home Adults	$548,244	$1,133,001	$1,169,370	$1,206,907	$1,245,649
Total Existing Program Costs	$20,077,976	$41,493,145	$42,825,074	$44,199,759	$45,618,572
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$13,153,082*	*$27,265,145*	*$28,140,356*	*$29,043,662*	*$29,975,963*
State Share	*$6,924,894*	*$14,227,999*	*$14,684,718*	*$15,156,097*	*$15,642,608*
I-Option Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	124	124	124	124	124
Total ACH	$0.00	$28,479,093	$29,393,272	$30,336,796	$31,310,607
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	124	124	124	124	124
Total In-Home Adults	$0.00	$1,076,624	$1,111,183	$1,146,852	$1,183,666
Total I-Option Program Costs	$0	$29,555,716	$30,504,455	$31,483,648	$32,494,273
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$0*	*$19,421,061*	*$20,044,477*	*$20,687,905*	*$21,351,987*
State Share	*$0*	*$10,134,655*	*$10,459,978*	*$10,795,743*	*$11,142,286*
Additional Costs/(Savings)	***0***	***($11,937,428)***	***($12,320,620)***	***($12,716,112)***	***($13,124,299)***
Federal Share	***0***	***($7,844,084)***	***($8,095,879)***	***($8,355,757)***	***($8,623,977)***
State Share	***0***	***($4,093,344)***	***($4,224,740)***	***($4,360,355)***	***($4,500,322)***

Change in Eligibility

SFY 2014	SFY 2015	SFY 2016	SFY 2017
3.33%	*3.21%*	*3.21%*	*3.21%*

$3.88 *Cost/Unit*

$4.46 *Cost/Unit*

Notes:

1. *I-Option Program effective date is 07/01/2013*
2. *SFY2013 represents 6 months of existing program costs; additional cost/savings not applicable*
3. *Average Units/Month and Cost/Unit remain unchanged*

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 disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Individualized Support Services

2. Statewideness. *(Select one)*:

●	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
○	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:

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 Medical Assistance, North Carolina Department of Health and Human Services
	○	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):

Items 1, 2, 4, 5 (HCBS enrollment, eligibility, service authorization and utilization management): DMA contracts with a private vendor to determine eligibility for 1915(i) services, complete the independent assessment/reassessment, and authorize the appropriate amount of service for each individual according to 1915(i) service criteria. The private vendor will not be a provider of the 1915(i) benefit. DMA retains full and final responsibility and authority for all Individualized Support operations including services provided by contracted entities and providers. DMA monitors the operations through the quality assurance program. DMA monitors contractors according to the State's performance based contracting requirements.

Items 6 & 7 (provider enrollment): DMA contracts with Computer Sciences Corporation (CSC) to credential and enroll qualified providers. CSC has been selected to be the new MMIS vendor and the transition of all MMIS activities from Hewlett Packard to CSC is currently underway.

Item 10 (QA/QI): The administrative entity under contract to DMA will assist with remediation when quality of care issues are identified.

(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 provider 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):*

Note: The assessments are completed by an independent entity and the plans of care are completed by the provider based on assessment findings. The independent assessor determines eligibility for service and the amount of service and the provider completes the plan of care based on the needs identified in the assessment and the individual's preferences as to how/when/by whom the service will be provided.

Plans of care are reviewed by the independent assessor for compliance with the assessed limits, duration, and scope. Once reviewed by the independent assessor The State Medicaid Agency monitors the plan of care for services approved for compliance and reimbursement through this web based assessment and care planning tool.

The Independent Assessment Entity reviews all completed plans of care for compliance with the results of the independent assessment of the individual. Once approved by the IAE, plans of care are sent to the State Medicaid Agency for final approval.

The State's quality improvement strategy also includes performance measures addressing the timeliness, appropriateness and the required IAE review of plans of care.

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 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.

Target Group(s)

X **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. 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).

Target Population	Adults with I/DD Diagnoses
Population Definition Age, Diagnoses, and Physician*-Documented Functional Limitations	Medicaid beneficiaries age 18 or older with a documented I/DD diagnosis that a physician attests limits the person's ability to independently acquire, improve, and retain skills needed for the beneficiary to participate in home life or community activities.

(*Specify target group(s)*):

* "Physician" may be the individual's primary care or physician or a designee who is a nurse practitioner (NP) or physician's assistant (PA).

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	1/1/13	1/1/14	4500

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. ☑ Income **Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

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 at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
☑	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). 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 with contract with the State Medicaid agency*):
	Evaluations and reevaluations of individuals for 1915(i) eligibility will be performed by entities under contract to the Division of Medical Assistance (DMA). Due to the large volume of applicants/participants, DMA will contract with as many qualified vendors as needed to ensure that evaluations are completed in a timely manner while maintaining oversight with these evaluations. DMA currently has a contract with the Carolinas Center for Medical Excellence (CCME) to conduct evaluations. The vendor(s) conducting the evaluations and reevaluations will not under any circumstances be providers of 1915(i) services. Written conflict of interest safeguards will be included in the contracts/agreements with the entities to address any potential conflicts.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. 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):*

Evaluators must meet the requirements of the NC DHHS job classifications of Public Health Nurse I, II or higher or Social Worker I, II or higher, as follows:

NC Office of State Personnel - Public Health Nurse I Position Description Requirements:

Knowledge, Skills, and Abilities - Considerable knowledge of and skill in the application of nursing theory, practices, principles, and techniques employed in the field of public health and related programs; general knowledge of and ability to apply the principles and practices of public health; working knowledge of current social and economic problems relating to public health; working knowledge of available resources and organizations. Ability to deal tactfully with others and to exercise good judgment in appraising situations and making decisions; ability to secure the cooperation of clients, to elicit needed information and to maintain effective working relationships; ability to record accurately services rendered and to interpret and explain records, reports and medical instructions; some ability to plan, coordinate, and supervise the work of others.

Minimum Training and Experience - Graduation from a four-year college or university with a B.S. Degree in Nursing which includes a Public Health Nursing rotation; or graduation from an accredited school of professional nursing and one year of professional nursing experience; or an equivalent combination of training and experience. Necessary Special Qualifications - A current license to practice as a Registered Nurse in North Carolina by the North Carolina Board of Nursing.

NC Office of State Personnel - Social Worker I Position Description Requirements:

Minimum Education and Experience Requirements: Bachelor's degree in a human services field from an accredited college or university; Bachelor's degree from an accredited college or university and one year directly related experience. *Directly related experience is defined as human services experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning. Degrees must be received from appropriately accredited institutions.

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 process begins with a written referral for an assessment for 1915(i) services from the individual's physician, nurse practitioner or physician assistant. The referral documents the individual's overall health status and characteristics related to the target population criteria, including primary and secondary diagnoses, need for caregiver availability, and risk for falls, skin breakdown, malnutrition, and complications from medication noncompliance. If the referred individual meets target population criteria, an independent assessment entity under contract to the Division of Medical Assistance will have 15 business days from receipt of the referral to contact the applicant, complete an evaluation of eligibility and a face-to-face assessment. The independent assessment will determine both eligibility for 1915(i) services and authorized service level. The assessor will also document the beneficiary's provider of choice. If a beneficiary or family doesn't have a provider of choice, the assessor will give

the beneficiary a list of providers in the beneficiary's geographic area.

Individualized Support Services may be provided in two settings: the person's private residence or a HCBS compliant licensed residential facility. The assessment will identify options as to living arrangement for the receipt of services and refer eligible individuals to the provider(s) of their choice.

The existing In-Home Care population undergoes an independent assessment conducted by an independent assessor (qualified RN) using a standardized assessment tool that is used to determine benefit eligibility and service level. Maintaining the Patient Centered focus, the provider agency RN incorporates the beneficiary needs identified in the assessment based on service definitions to create the individualized plan of care. The tool addresses the same qualifying ADLs and IADLs that are included in the proposed Individualized Support eligibility criteria. Level of assistance needed is scored as supervision/set up; limited hand-on; extensive; or total/full dependence.

The state asserts that all In-Home beneficiaries who qualified on the basis of an independent assessment conducted within the 12 months prior to implementation of the 1915(i) Individualized Support benefit and using the current in-home assessment tool meet the proposed eligibility criteria. The State will use the same standardized tool to assess all current ACH residents to determine eligibility and level of service under the 1915(i) Individualized Support benefit. Annual reassessment will be required of all beneficiaries to determine continuing eligibility and service levels, and all beneficiaries transitioned on the basis of a previous assessment under the In-Home Care program will be revaluated within 12 months of the previous assessment. If a beneficiary changes location (such as moving from a residential setting to home and is eligible for Medicaid) and has received an independent assessment within the last 12 months, then Individualized Support services will continue. The State will use the standardized assessment tool or a comparable alternative to assess all new Individualized Support referrals and continuing beneficiaries post-implementation.

The evaluation/assessment process and tools are used for all annual reevaluations/reassessments and reevaluations/reassessments due to change in needs.

4. ☑ Needs-**based HCBS Eligibility Criteria:**

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):*

Applicants will be assessed for 1915(i) eligibility based on their independent support needs (i.e.,their need for assistance with qualifying activities of daily living (ADLs) and IADLs.)

Activities of Daily Living:

Activities of Daily Living (ADLs) are common self-care tasks necessary for independent living. In North Carolina, for the purposes of the 1915(i), there are a total of five (5) assessed ADLs: Bathing, Dressing, Mobility, Toileting, and Eating. Need for assistance with one or more ADLs is determined by an independent assessment. Depending on the specific target group, the need for these ADLs must be linked to a documented condition or risk. Applicants may also benefit from habilitation services aimed at acquiring, improving, and retaining these skills.

Instrumental Activities of Daily Living (IADLs)

Instrumental activities of daily living are specific activities that are crucial to an individual's welfare. In North Carolina, for the purposes of the 1915(i), there are only two (2) qualifying IADLs: Meal Preparation and Medication Assistance.

The following Table outlines the Basic Eligibility Criteria for the three 1915(i) target populations.

Target Population	Adults with I/DD Diagnoses
Eligibility Criteria Established by the individual's physician-documented risk and need for caregiver availability and an independent functional assessment of the person's individual support needs.	Individuals have physician-documented need for caregiver availability and any of the following need profiles: Unmet need for hands-on assistance with two (2) ADLs and set up/supervision assistance including cueing/prompting with an expectation of skill building with one ADL.

5. ☑ **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):*

Needs-Based/Level of Care (LOC) Criteria

Column III **ICF IID (& ICF IID LOC waivers)**
In order to be Medicaid-certified at an **ICF IID** level of care, an individual must meet the following criteria: 1. Require active treatment necessitating the **ICF IID** level of care; **and** 2. Have a diagnosis of intellectual disability, Intelligence Quotient (IQ) test results indicating intellectual disability, or a condition that is closely related to intellectual disability. a. Intellectual Disability is 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. b. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions: i. is attributable to: (a) Cerebral palsy, epilepsy; **or** (b) Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior, and requires treatment or services similar to those required for these persons; **and**; ii. The related condition manifested before age 22; **and** iii. Is likely to continue indefinitely; **and** iv. Have a diagnosis of intellectual disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas: (a) Self-Care (ability to take care of basic life needs for food, hygiene, and appearance) (b) Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally) (c) Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations) (d) Mobility (ambulatory, semi-ambulatory, non-ambulatory) (e) Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life) (f) Capacity for independent living (age-appropriate ability to live without extraordinary assistance). **Note:** Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

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

6. ☑ Reevaluation **Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ 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). However, if the State chooses to revise its needs-based eligibility criteria, it must continue offering 1915(i) services in accordance with individual service plans to participants who do not meet the new revised needs-based criteria, but continue to meet the former needs-based criteria, for as long as the State plan HCBS option is authorized.

8. ☑ Residence **in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

North Carolina's 1915i State Plan Individualized Support Services benefit requires Individualized Support to be individualized based on the individual's needs identified through an independent assessment and person centered-planning process. There is not an automatic process for individuals to receive Individualized Support services. An individual must be referred to Individualized Support through a physician referral that is submitted to the independent assessment entity designated by the Division of Medical Assistance (DMA). An individual is given choice to select a provider to receive Individualized Support. A provider is required to use a person centered planning process to develop a plan of care (PCP) for an eligible beneficiary. The beneficiary and the provider decide together on the delivery of Individualized Support.

The choice of living and receiving Individualized Support in a private residence or a residential setting is determined by the beneficiary or beneficiary's responsible party. In accordance to licensure rules 10A NCAC 13F&G; and 27D the residential setting providers shall have a resident admission contract or agreement upon admission to the facility.

Recipients are informed at the time of assessment that Individualized Support may be provided in a private residence or residential setting and asked to indicate their preferred setting and provider. Depending on the beneficiary preference, individuals applying for Individualized Support will be asked to select preferred providers from those serving the beneficiary's preferred geographic location(s) and setting, which may be a private residence and/or residential facility. Continuing beneficiaries may elect at reassessment or at any time by requesting a change of provider to receive services from a different provider and/or a different setting.

The beneficiary has rights in accordance with North Carolina General Statutes § 131D-19 Article 3 adult care home residents' bill of rights or North Carolina General Statutes § 122C-51 Article 3 clients' rights. The beneficiary's rights are promoted through the use of the person centered planning process. The opportunity to exercise personal freedom in all domains will be promoted through qualified staff of the residential care settings. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. Personal freedom and choice must be applied to all beneficiaries of residential care settings except where such activities or abilities are contraindicated specifically in an individual's person centered plan as discussed during the person centered planning process. Community integration has many elements and is dependent on the beneficiary's preferences and availability. Establishing choices for each beneficiary is a process of asking, learning, and providing the accessibility to services, supports and naturally occurring activities offered to anyone in the community.

North Carolina's 1915i State Plan Option Individualized Support Services is offered in private residences and in residential settings other those of private residences. The residential settings are Adult Care Homes and Supervised Living Facilities. The state has administrative rules and quality oversight that assure individual's rights and safety in these residential settings. These settings are not located in buildings that are publicly or privately operated facilities that provide inpatient institutional treatment, or in buildings on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex.

- **Adult Care Home** is defined in North Carolina General Statutes as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. NC General Statute 131-D-19 implements a bill of rights for residents of adult care homes to ensure residents' right to privacy, autonomy, and independence, and the right to be treated with respect and dignity. The statute calls for residents to have maximum choice and decision making while putting processes in place to prevent abuse, neglect and exploitation. All residents receive upon admission to the adult care home a written copy of the bill of rights. State law requires adult care homes to provide and maintain specific services and living arrangements that promote a home environment which maximizes consumer choice, control and privacy, and enables consumers to participate in community activities with both other consumers and non-consumers.

- **Supervised living facilities,** described in North Carolina Administrative Code 10A 27G .5601-5603, are group homes for adults with mental illness or developmental disabilities. These homes can be licensed to serve a maximum of six adults at any given time. North Carolina General Statutes § 122C-51 encourages that client's rights include the right to

dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. The "5600A" homes are for adults with a primary diagnosis of mental illness and "5600C" homes are for adults with a primary diagnosis of a developmental disability. Supervised living facilities are subject to licensure by the Division of Health Service Regulation. The homes are located in residential neighborhoods for maximum community integration, which provides residents with easy access to community activities, programs and supports.

Home and Community Living Standards

The 1915i State Plan Individualized Support Services benefit requires that all residential providers adhere to the North Carolina General Statutes § 131D-19, Adult Care Home Residents' Bill of Rights and the North Carolina General Statutes § 122C-51, Clients' Rights and Advance Instruction. The North Carolina Department of Health and Human Services (DHHS), Division of Health Service Regulation (DHSR) inspects and licenses residential providers on an annual basis. This annual review will assist in the ongoing monitoring to ensure Residential providers are continuing to meet HCBS.

Article 3
Adult Care Home Residents' Bill of Rights

§ 131D-19

It is the intent of the General Assembly to promote the interests and well-being of the residents in adult care homes and assisted living residences licensed pursuant to Part 1 of this Article. It is the intent of the General Assembly that every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist the resident in the fullest possible exercise of these rights. It is the intent of the General Assembly that rules developed by the Social Services Commission to implement Article 1 and Article 3 of Chapter 131D of the General Statutes encourage every resident's quality of life, autonomy, privacy, independence, respect, and dignity and provide the following:

(1) Diverse and innovative housing models that provide choices of different lifestyles that are acceptable, cost-effective, and accessible to all consumers regardless of age, disability, or financial status;

(2) A residential environment free from abuse, neglect, and exploitation;

(3) Available, affordable personal service models and individualized plans of care that are mutually agreed upon by the resident, family, and providers and that include measurable goals and outcomes;

(4) Client assessment, evaluation, and independent case management that enhance quality of life by allowing individual risk-taking and responsibility by the resident for decisions affecting daily living to the greatest degree possible based on the individual's ability; and

(5) Oversight, monitoring, and supervision by State and county governments to ensure every resident's safety and dignity and to assure that every resident's needs, including nursing and medical care needs if and when needed, are being met. (1981, c. 923, s. 1; 1995, c. 535, s. 12; 2009-462, s. 4(g).)

Article 3
Clients' Rights and Advance Instruction

§ 122C-51

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities. (1973, c. 475, s. 1; c. 1436, ss. 1, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 7; 1997-442, s. 1.)

North Carolina Residential Settings
Home and Community Setting (HCBS) Characteristics

Residential setting providers shall adhere to the NC Home and Community living characteristics and North Carolina General Statutes § 131D-19, and § 122C-51 (Adult Care Home Residents' Bill of Rights and Clients' Rights and Advance Instruction) in order to be eligible to provide home and community based services (HCBS).

Home and community setting characteristics must be met by all residential settings. Home and community setting characteristics must be applied to all individuals in the facility 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 characteristics or rights. Individuals must be respectful to others in their community and the facility has the authority to restrict activities when those activities are disruptive or in violation of the rights of others living in the community.

A. Telephone Access

Review of person centered plan to determine if any phone limitations are individualized, based individual safety and

treatment needs and documented in the Person Centered Service Plan. Observation of facility phone area for ease of access and privacy, staff and individual interviews to determine if 24/7/365 access and assistance are available.

B. Visitors
Review of person centered plan to determine if any limitations on visitors are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Individual interviews about their ability to have visitors and any restrictions placed on visitation by the facility. Staff interviews to determine their understanding of the facility visitation policy and how it is implemented. Review of facility visitation policy. "Facilities maintain the right to restrict or ban visitors identified to be disruptive or dangerous to the health and safety of other residents."

C. Living Space
Review of person centered plan to determine if any limitations on individuals' abilities to lock their rooms, decorate roommate choice and come and go at will are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Review of facility policy. Staff interviews to determine their understanding of the facility policies and how they are implemented in the facility.

D. Service Customization
Review of the person centered plan to determine individual's involvement is documented. Observation of individual and staff interaction to assure treatment and privacy needs are met. Conduct resident interview to determine individual understanding of their individualized plan and their involvement in development of the plan. Facility staff interview to determine their understanding of the individual's individualized plan and the individual's role in directing service delivery.

E. Food Access
Review of person centered plan to determine if any limitations on individuals' abilities to access the kitchen are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of meal and/or food storage in residential setting; Interview with individuals regarding their opportunity to have input into the food served, when and with whom they dine.

F. Group Activities
Review of person centered plan to determine if any limitations on individuals' abilities to participate in recreational choice are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of recreational activities if possible during survey; Individual and staff interview to determine what choices of recreational activities are offered and individual's input into decisions regarding participation.

G. Community Activities
Review of person centered plan to determine if any limitations on individuals' abilities to participate in community activities are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of community activities if possible during survey; Individual and staff interview to determine what choices of community activities are available and individual's input into decisions regarding participation.

H. Community Integration
Review of person centered plan to determine if any limitations on individuals' abilities to participate in community integration are individualized, based on individual treatment needs and safety and documented in the Person Centered Service Plan. Individual interview to determine in what ways the individual feels the facility is part of the community and their desired activities to strengthen community involvement.

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 is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☑ Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Identifies the individual's choice of setting from among all available alternatives;
   - Includes those services, the purchase or control of which the individual elects to self-direct,
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **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 physical and mental needs for HCBS. *(Specify qualifications):*

The independent assessment entities are responsible for conducting both the evaluation for service eligibility and the face-to-face assessments. These activities are conducted by registered nurses or social workers who meet the following requirements:

Evaluators must meet the requirements of the NC DHHS job classifications of Public Health Nurse I, II or higher or Social Worker I, II or higher, as follows:

NC Office of State Personnel - Public Health Nurse I Position Description Requirements:

Knowledge, Skills, and Abilities - Considerable knowledge of and skill in the application of nursing theory, practices, principles, and techniques employed in the field of public health and related programs; general knowledge of and ability to apply the principles and practices of public health; working knowledge of current social and economic problems relating to public health; working knowledge of available resources and organizations. Ability to deal tactfully with others and to exercise good judgment in appraising situations and making decisions; ability to secure the cooperation of clients, to elicit needed information and to maintain effective working relationships; ability to record accurately services rendered and to interpret and explain records, reports and medical instructions; some ability to plan, coordinate, and supervise the work of others.

Minimum Training and Experience - Graduation from a four-year college or university with a B.S. Degree in Nursing which includes a Public Health Nursing rotation; or graduation from an accredited school of professional nursing and one year of professional nursing experience; or an equivalent combination of training and experience. Necessary Special Qualifications - A current license to practice as a Registered Nurse in North Carolina by the North Carolina Board of Nursing.

NC Office of State Personnel - Social Worker I Position Description Requirements:

Minimum Education and Experience Requirements: Bachelor's degree in a human services field from an accredited college or university; Bachelor's degree from an accredited college or university and one year directly related experience. *Directly related experience is defined as human services experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning. Degrees must be received from appropriately accredited institutions.

In addition, trainees must undergo additional State developed training including but not limited to: conducting the evaluation/assessment using the State's Independent Assessment tool; using the web based system for recording assessment data; participating in appeals; identifying and reporting alleged fraud, abuse and neglect.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Providers of Individualized Support Services, including home care agencies, adult care homes and supervised living facilities, develop the plan of care. These plans of care are driven by the information provided through the 1915(i) Independent Assessment including the suggested plan of care and all identified triggers. Please see the provider qualifications section for more detail about licensure requirements and other qualifications. Plans of care must be developed within 15 days of acceptance of the beneficiary who has been evaluated and assessed by DMA's independent assessment entity. All plans of care must be reviewed by the independent assessment entity for correctness and then approved by DMA before

payment of services can commence.

The plan of care must incorporate paid and unpaid services as it relates to participant needs - including health, safety, and welfare requirements.

Plans of care must have a back-up or emergency plan to address unanticipated needs such as last-minute unavailability of the aide, need for additional services short-term due to a change in status, etc. There will be flexibility within the service allocation during individual months and from month to month as long as the overall annual limit is not exceeded. Family/informal supports will be expected to participate in the back-up/emergency plan. The back-up plan and flexibility with service hours address temporary changes in need. If a person's needs appear to be changing over the long term, the individual will be assessed for other services, levels of care and/or service settings.

Individualized Support Services will be provided based on individual needs as identified in the independent assessment and on a one-to-one basis whether in a group setting or private home. If it is determined that an individual does not meet or ceases to meet the criteria for Individualized Support under 1915(i), notice will be provided and the individual will have appeal rights.

Residents may be admitted by choice in an adult care home, family care home, or supervised living home prior to being assessed for 1915(i) services. However, 1915(i) services will not be provided until the independent assessment is conducted and services authorized except on an emergency basis as approved by the State.

A Web-based Automated Tool is the platform for the 1915(i) independent assessment and the individual plan of care. Recipients may request and receive a copy of the completed assessment at any time from the Independent Assessment Entity. INDIVIDUALIZED SUPPORT provider organizations will maintain copies of completed assessments and also may provide copies to beneficiaries.

The Automated Web-based Tool which coordinates the 1915(i) Independent Assessment and the1915 (i) Individual Plan of Care is accessible by:

- 1915(i) independent assessment entities
- 1915(i) service providers
- State Medicaid Agency (SMA) and
- DHHS Division of Health Service Regulation

Independent assessor evaluates eligibility for need of 1915(i) services and the level of service need; the assessment tool identifies the individual's specific needs for assistance and the service provider finalizes the plan of care based on the assessment data and the consumer's preferences as to how and when and by whom services will be delivered.

Plans of care are reviewed by the independent assessor for compliance with the assessed limits, duration, and scope. Once reviewed by the independent assessor The State Medicaid Agency monitors the plan of care for services approved for compliance and reimbursement through this web based assessment and care planning tool.

5. **Supporting the Participant in Plan of Care Development.** 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 plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Meetings to develop the plan of care are scheduled taking into consideration times that are convenient for the participant and others involved in the care planning process. Participants are informed verbally of their authority, both by the assessment entity and the provider, to determine who will be included in the care planning process. The participant is the sole authority when making decisions unless a responsible party or guardian has been given authority to make decisions on the participant's behalf.

Regarding children under the age of 21 who apply for 1915(i) services it should be noted that when DMA or DMA's vendors review covered state Medicaid plan services requests for prior approval or continuing authorization for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a beneficiary under 21 years of age is a request for EPSDT services. The decision to approve or deny the request will be based on the beneficiary's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition]. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply to beneficiaries under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

6. **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 plan of care):*

The Independent Assessment Entity provides the participant with a list of all enrolled Medicaid providers of 1915(i) services within the participant's geographic area. The participant will be asked if any preferences exist such as a certain county or location. The IAE also provides beneficiaries with information on any available ratings or findings by regulatory or oversight agencies that might help them in making an informed decision or select a provider that meets their specific needs. The list is randomized electronically so facilities are never listed in the same order.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The Independent Assessment Entity reviews all completed plans of care for compliance with the results of the independent assessment of the individual. Once approved by the IAE, plans of care are sent to the State Medicaid Agency for final approval.

The State's quality improvement strategy also includes performance measures addressing the timeliness, appropriateness and the required IAE review of plans of care.

8. **Maintenance of Plan of Care 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 via web-based assessment/care planning system	☐	Operating agency	☐	Case manager

☑	Other (*specify*):	Provider

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: Individualized Support (IS)

Service Definition (Scope):

Individualized Support provided under this 1915(i) Benefit consists of training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes focus on allowing the beneficiary to participate in home life activities and reside as independently as possible in the community. This includes assistance in community activities when the beneficiary is dependent on others to ensure health and safety. Individualized Support also provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for adults with a diagnosis of Intellectual/Developmental Disability. ADLs, for the purposes of this benefit, are defined as eating, dressing, bathing, toileting, and mobility. IADLs are meal preparation, medication assistance, and basic home management tasks that are directly related to the qualifying ADLs and essential to the beneficiary's care at home.

Individualized Support is provided during community activities, in the beneficiary's home by paraprofessional aides employed by licensed home care agencies, in licensed adult care homes, or supervised living homes by residential staff. For the purposes of this benefit, the beneficiary's home may be a private living arrangement a residential facility licensed by the State of North Carolina as an adult care home, a family care home, or a supervised living facility for adults with Intellectual/Developmental Disabilities.

The amount of service provided is based on an assessment conducted by an independent entity to determine the individual's support needs. Performance is rated as totally independent, requiring cueing or supervision, requiring limited assistance, requiring extensive assistance or totally dependent. Individuals are then assigned a number of service increments according to their assessed needs.

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

The following additional requirements must be met for an individual to receive the service in his or her private living arrangement:

1. The home environment is safe and free of health hazards for the beneficiary and IS provider(s), as determined by an in-home environmental assessment conducted by Medicaid or its designee. An environmental assessment looks at the physical characteristics of the home to determine whether it is habitable or poses obvious risks

to individuals living and/or providing services in the home; for example, does the home have electricity, a source of heat in cold weather, infestation by rodents/insects or rotting floors that are dangerous to walk on.
2. The home is adequately equipped to implement needed services.
3. There is no available, willing, and able household member to provide the authorized services on a regular basis.

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

☑ Categorically needy *(specify limits)*:

Adults 21 years of age and older may be authorized for no more than 60 hours of service per month.

When medication assistance is delivered in private residences it consists of medication self-administration assistance as allowed by state law in 10A NCAC 13J .1107. When medication assistance is delivered in adult care homes it may include medication administration as defined in 10A NCAC 13F & G.1004. When medication assistance is delivered in supervised living homes it may be done in accordance to 10A NCAC 27G. 0209. Authorized Individualized Support hours in adult care homes do not cover basic meal preparation or errands services that duplicate state- and county-funded room and board services.

☑ Medically needy *(specify limits)*:

Same as above.

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Care Homes	Licensed in accordance with NC General Statute 131D and North Carolina Administrative Code Title 10A, Chapter 13, Subchapters F and G.		Service is provided by the Adult Care Home either through their own staff or through qualified staff under contract to provide the service. Staff providing services must meet the training, competency and other requirements applicable to direct care workers found in 10A NCAC 13F and 13 G. Staff who prepare and administer medications must meet all applicable requirements for medication aides in 10A NCAC 13F and 13G. Medications must be stored, maintained and managed according to the requirements of 10A NCAC 13F and 13G. Criminal records and health care registry checks are required for all adult care home staff.

Supervised Living	NC General Statute 122-C and 10A NC Administrative Code 27G 5600, Supervised Living Facilities, designated as type A and C homes		•Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200. •Staff must have a high school diploma or GED •Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan. •Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training. •Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. •Must have a criminal record check •A healthcare registry check is required in accordance with 10A NCAC 27G.0200
Home Care Agencies	Licensed under NC Administrative Code Title 10A, Chapter 13, Subchapter J		Criminal background checks must be conducted on all In-Home Aides before they are hired. In-Home Aides cannot be hired if listed on the North Carolina Health Care Registry as being under investigation or as having a substantiated finding of previous client abuse or neglect, misappropriation of client property, diversion of client or facility/program drugs, or fraud as an employee of one of the reporting health facility types.

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)*:
Adult Care Homes	**The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses adult care homes. DHSR reviews will include monitoring to ensure facilities continue to meet HCBS criteria.**	**Annually**
Supervised Living	**The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses supervised living homes. DHSR reviews will include monitoring to ensure facilities continue to meet HCBS criteria.**	**Annually**
Home Care Agencies	**The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses home care agencies.**	**Annually**

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) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) 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):*

Services may not be provided by relatives and/or legal guardians of 1915(i) participants.

Participant-Direction of Services

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

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

⊙	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):*

N/A

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*):
	N/A

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
N/A	☐	☐
	☐	☐

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 Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. 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

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(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). *(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 how the method makes use of reliable cost estimating information, 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 plan of care):*
	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):*
	N/A

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	**Assurance 1**: All new referrals admitted to (i) Option Individualized Support Services (IS) benefit will receive an Independent Eligibility Assessment (IEA) **1)** Performance Metric: Number and percent of cases sampled where individuals admitted to Individualized Support as new referrals in the previous month received a PEA **A)** Numerator = Number of new referrals admitted to Individualized Support in prior month receiving a PEA **B)** Denominator = Total number of new referrals admitted in the review period	Data Source: QiRePort Sampling: **1)** Type of Sample: Random sample of new referrals admitted to Individualized Support in previous month **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month for the previous month based on the 95% confidence level	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: Program Administration Contractor's (PAC) QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 2: All (i) Option Individualized Support participants will be re-assessed for continuation of services prior to their annual review date. **1)** Performance Metric: Number and percent of Individualized Support participants in sample of individuals with an annual review date in the previous month, who received a re-assessment prior to their annual review date	Data Source: QiRePort Sampling: **1)** Type of Sample: Stratified random sample **2)** Strata: Strata include re-assessments performed on 1915(i) benefit participants receiving Individualized Support in: **a)** Adult Care Homes (ACH) **b)** Family Care	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	A) Numerator = Number of participants who received an annual re-assessment prior to their annual review date **B)** Denominator = Number of participants reviewed during the review period	Homes (FCH) **c)** Supervised Living Homes (SLH) **d)** Privately-Owned Homes (POH) **3)** Sampling Frequency: Monthly **4)** Sample Size: Determined each month for previous month for each strata based on the 95% confidence level				
	Assurance 3: All new referrals, re-assessments, and change of status reviews for Individualized Support will be assessed within 15 business days of a valid request. Cases where technical denials have been generated are not included in the sampling. **1)** Performance Metric: Total number and percent of previous month sample of new referral assessments and re-assessments performed within the 15 business day timeframe **A)** Numerator = Number of PEA assessments and re-assessments conducted in previous month that were performed within the required timeframe **B)** Denominator = Number of assessments performed in review period	Data Source: QiRePort Sampling: **1)** Type of Sample: Random sample of assessments and re-assessments performed in previous month **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month for previous month based on the 95% confidence level	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 4: All assessments and re-assessments shall be conducted by a qualified assessor **1)** Performance Metric:	Data Source: QiRePort Sampling: **1)** Type of Sample: Random sample of assessments and re-	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues:	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Total number and percent of assessments and re-assessments conducted by a qualified assessor **A)** Numerator = Number of cases reviewed where the assessment was conducted by a qualified assessor **B)** Denominator = Number of cases reviewed in the review period	assessments performed in previous month **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month for previous month based on the 95% confidence level Who Aggregates and Analyzes: DMA QI Analyst			PAC QI Manager Who Tracks Remediation: DMA QI Manager	
	Assurance 5: All Individualized Support Providers accepting new referrals for Individualized Support will complete a person-centered POC that addresses the assessed needs of the Individualized Support participant. **1)** Performance Metric: Number and percent of POCs submitted to and approved by the Program Administration Contractor **A)** Numerator = Number of POCs reviewed that meet program standards and criteria for plan of care **B)** Denominator = Number of POCs reviewed during review period	Data Source: QiRePort Sampling: **1)** Type of Sample: Random sample of plans of care submitted in previous month **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month based on plans of care submitted in previous month based on the 95% confidence level	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 6: All Individualized Support Providers will complete an updated person-centered POC following an annual re-assessment within 20 business days of the reassessment **1)** Performance Metric:	Data Source: QiRePort Sampling: **1)** Sample Type: Random Sample **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Number and percent of POCs submitted to and approved by the DAC **A)** Numerator = Number of participants with updated POCs within time frame **B)** Denominator = Number of participants reviewed during review period	for the previous month based on the 95% confidence level			Remediation: DMA QI Analyst	
	Assurance 7: Each POC shall document participant choice of provider **1)** Performance Metric: Total number and percent of plans of care that document participant choice of provider **A)** Numerator = Number of participants reviewed with a plan of care that documents provider choice **B)** Denominator = Number of participants reviewed during review period	Data Source: QiRePort Sampling: **1)** Sample Type: Random sample of plans of care submitted in previous month **2)** Sampling Frequency: Monthly **3)** Sample Size: Determined each month for previous month based on the 95% confidence level	IT Support Vendor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
Providers meet required qualifications.	**Assurance 1**: All Individualized Support furnished to qualified beneficiaries in their private residences shall be provided by home care agencies licensed by the North Carolina Division of Health Services Regulation (DHSR) and properly enrolled with North Carolina Medicaid to provide in Individualized Support in POHs. **1)** Performance Metric: Number and percent of home care agencies that received appropriate licensure by the DHSR prior to the provision of 1915(i) benefit services to	Data Source: MMIS report Sampling: **1)** Sampling Type: Random sample of claims filed by home care agencies to determine how many were denied because they were not enrolled providers **2)** Sampling Frequency: Quarterly **3)** Sample Size: Determined each quarter for claims filed by home care agencies for services to	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Quarterly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	participants in the POH setting **A)** Numerator = Number of home care agencies providing services that received appropriate licensure by DHSR prior to providing services to 1915(i) benefit participants **B)** Denominator = All home care agencies submitting claims during the review period	beneficiaries in the POH setting for previous quarter based on the 95% confidence level				
	Assurance 2: All Individualized Support furnished to qualified beneficiaries in the adult and family care homes will be provided by adult and family care homes licensed by the North Carolina DHSR and properly enrolled with North Carolina Medicaid as an adult or family care home provider, as applicable. **1)** Performance Metric: Number and percent of adult and family care homes that received appropriate licensure by the DHSR prior to the provision of 1915(i) benefit services **A)** Numerator = Number of adult and family care homes that received appropriate licensure by DHSR prior to providing services to participants **B)** Denominator = All adult care homes submitting claims during the review period	Data Source: MMIS report Sampling: **1)** Sampling Type: Random sample of claims filed by adult and family care homes to determine how many were denied because they were not enrolled providers **2)** Sampling Frequency: Quarterly **3)** Sample Size: Determined each quarter for claims filed by adult and family care homes for Individualized Support provided to residents for previous quarter based on the 95% confidence level	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Quarterly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Assurance 3: All Individualized Support furnished to qualified beneficiaries in Supervised Living Homes that received appropriate licensure by DHSR prior to provision of 1915(i) benefit services. 1) Performance Metric: Number and percent of SLHs that continue to be licensed by the DHSR on an annual basis **A)** Numerator = Number of supervised living homes that received appropriate licensure by DHSR prior to providing services to 1915i) benefit participants **B)** All supervised living homes submitting claims during the review period	Data Source: MMIS reports Sampling: 1) Sample Type: Random sample of claims filed by supervised living homes to determine how many were denied because they were not enrolled providers 2) Sampling Frequency: Quarterly 3) Sample Size: Determined each quarter for claims filed by Supervised Living Homes for Individualized Support provided to qualified beneficiaries in the SLH for previous quarter based on the 95% confidence level	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Quarterly
	Assurance 4: All Individualized Support shall be provided by paraprofessional aides meeting the qualifications and training competencies specified in licensure requirements for home care agencies, adult care homes, family care homes, and supervised living homes, as appropriate 1) Performance Metric: Number and percent of cases reviewed where services are provided by an individual meeting all professional requirements for paraprofessional aide applicable to home care agencies, adult care homes, family care homes, and	Data Sources: 1) Desktop reviews of selected cases where providers are asked to confirm that specified aides meet all professional qualification and training requirements 2) On-site review of personnel and training records Sampling: 1) Sample Type: Stratified random sample 2) Strata include: **A)** Adult Care Homes **B)** Family Care Homes	DMA QI Analyst	Monthly	Who Aggregates and Analyzes: PAC QI Manager Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	supervised living homes, as appropriate **A)** Numerator = Number of cases reviewed where services were provided by a qualified paraprofessional aide Denominator: Number of cases reviewed during review period	**C)** Supervised Living Homes **D)** Privately-Owned Homes **3)** Sampling Frequency: Monthly **4)** Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases for each setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases for each setting type)				
	Assurance 5: The state shall determine participants' satisfaction with the quality of care and quality of Individualized Support Services furnished by the agency or home and the direct care staff. **1)** Performance Metric: Number and percent of beneficiaries in sample who rate their providers as satisfactory or higher **A)** Numerator = Number of participants who rated their provider satisfactory or higher **B)** Denominator = Number of Individualized Supports participants completing satisfaction survey during review period	Data Sources: **1)** Satisfaction surveys conducted as part of annual re-assessments **2)** Satisfaction surveys conducted as part of change of status re-assessments **3)** Satisfaction survey conducted with participants who have requested a change of provider Sampling: **1)** Type of Sample: Stratified random sample **2)** Strata: Strata include: **A)** Participants receiving annual re-assessment **B)** Participants receiving change of status re-assessments **C)** Participants requesting a	DMA QI Analyst and QI Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst and QI Contractor Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
		change of provider **3)** Sampling Frequency: Monthly **4)** Sample Size: Determined each month for previous month for each strata based on the 95% confidence level				
The SMA retains authority and responsibility for program operations and oversight.	**Assurance 1**: The North Carolina Division of Medical Assistance shall enter into contractual agreements with an independent assessment contract administrator, and IT Support Entity that establishes Medicaid authority over all program components. **1)** Performance Metrics: Number and percent of contractors with performance-based agreements establishing DMA authority and responsibility for 1915(i) benefit operations and oversight. **A)** Numerator = Number of agreements reviewed that fulfill this requirement **B)** Total reviewed during review period	Data Source: Program files and documents **1)** Written performance-based agreements; and **2)** Performance reviews Sampling: **1)** Sample Type: One hundred percent review of all contracts executed in review period **2)** Sampling Frequency: Quarterly **3)** Sample Size: All contracts, other agreements, and performance reviews	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Quarterly
	Assurance 2: The North Carolina Division of Medical Assistance shall monitor all clinical policy requirements and 1915(i) benefit administrative functions on an ongoing basis using an automated program management system. **1)** Performance Metrics: Total and percent of cases	Data Source: QiRePort Sampling: **2)** Sample Type: Random **3)** Sampling Frequency: Monthly **4)** Sample Size: Determined each month for the total 1915(i) benefit enrollment	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	meeting program standards for: **A)** Compliance with Medicaid Clinical Coverage Policy **i)** Numerator = Cases that meet performance standards for clinical policy requirements **ii)** Denominator – Total cases reviewed in review period **B)** Compliance with program administrative requirements **i)** Numerator: Cases that meet performance standards for program administration **ii)** Denominator = Total cases reviewed in review period	based on the 95% confidence level				
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	**Assurance 1**: The state shall ensure that all claims are paid in accordance with the number of hours of Individualized Support determined by the Independent Eligibility Assessment, specified in the service authorization, and documented in the beneficiary's plan of care. **1)** Performance Metric: Total and percent of claims sample paid in accordance with the approved amount of service **A)** Numerator = Number of claims paid in accordance with	Data Sources: **1)** QiRePort; **2)** Prior approval records in MMIS; and **3)** Paid claims records in MMIS Sampling: **1)** Sample Type: Random sample of paid claims **2)** Sample Frequency: Monthly **3)** Sample Size: Determined each month for the previous month based on the 95% confidence level	Program IT Contractor	Monthly	Who Aggregates and Analyzes: Program IT Vendor Who Addresses: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	approved service authorization **B)** Denominator = Total number of claims paid in review period					
	Assurance 2: The state shall ensure that all claims all claims paid are supported by documentation in the beneficiary's service record and provided in accordance with the beneficiary's plan of care. **1)** Performance Metric: Total and percent of claims sample paid in accordance with service record and plan of care **A)** Numerator = Claims paid in accordance with service record and plan of care **B)** Denominator = Total number of claims reviewed in review period	Data Source: Provider service records Sampling: **1)** Sampling Type: Stratified Random Sample of Cases **2)** Strata Include: **A)** Adult Care Homes **B)** Family Care Homes **C)** Supervised Living Homes **D)** Privately-Owned Homes **3)** Sampling Frequency: Monthly **4)** Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases per setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases per setting type)	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of	**Assurance 1**: All beneficiaries approved for Individualized Support under the (i) Option shall receive a copy of the Client's Bill of Rights and the 1915(i) HCBS Standards, as applicable to each setting type, and each provider shall ensure that receipt of these documents contains	Data Source: Provider service records Sampling: **1)** Sampling Type: Stratified Random Sample of Cases **2)** Strata Include: **A)** Adult Care Homes **B)** Family Care	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
restraints.	information on how to report critical incidents and submit complaints. Receipt of this Bill of Rights shall be documented in the participant's service record. **1)** Performance Metric: Number and percent of service records reviewed that contain: **i)** Information on reporting incidents and submitting complaints; and **ii)** A signed and dated acknowledgement that beneficiary has received a copy of the Client Bill of Rights **A)** Numerator = Number of reviews where performance metric is met **B)** Denominator = Number of cases reviewed during review period	Homes **C)** Supervised Living Homes **D)** Privately-Owned Homes **3)** Sampling Frequency: Monthly **4)** Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases per setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases per setting type)				
	Assurance 2: Home care agencies, adult care homes, and family care homes shall complete an Internet-based uniform reporting form for all specified critical incidents and submit this form to DMA (and all other agencies specified under applicable licensure rules) within XX business days **1)** Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe **A)** Numerator =	Data Source: Provider service records Sampling: **1)** Sampling Type: Stratified Random Sample of Cases **2)** Strata Include: **A)** Adult Care Homes **B)** Family Care Homes **C)** Privately-Owned Homes **3)** Sampling Frequency: Monthly	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Number cases reviewed that met reporting requirement **B)** Denominator = Total number reviewed during review period	4) Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases per setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases per setting type)				
	Assurance 3: Supervised Living Homes shall report all critical incidents utilizing the North Carolina Incident Response Improvement System (IRIS) for all specified critical incidents within XX business days. 1) Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe **A)** Numerator = Number cases reviewed that met reporting requirement **B)** Denominator = Total number reviewed during review period	Data Source: Provider service records Sampling: 1) Sampling Type: Stratified Random Sample of Cases 2) Strata Include: **A)** Supervised Living Homes 3) Sampling Frequency: Monthly 4) Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases per setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases per setting type)	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 4: Individualized Support assessments completed in the beneficiary's home shall include an inspection of the home and identification of any health or safety risks. 1) Performance Metric: Number and percent of in-home assessments that include a home health and safety inspection	Data Source: QiRePort Sampling: 1) Sample Type: Random sample 2) Sampling Frequency: Monthly 3) Sample Size: Sample Size: Determined each month for the previous month based on the 95%	Program IT Contractor	Monthly	Who Aggregates and Analyzes: PAC QI Manager Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	A) Numerator = Number of assessments that included a home health and safety inspection **B)** Denominator = Total number reviewed during review period	confidence level				
	Assurance 5: All aide and supervisory staff employed or under contract to the Individualized Support provider must have successfully passed a criminal history records check as required under NCGS 114-19.10, NCGS 131D-40, NCGS 122C-80, and health care personnel registry check as required by NCGS 131E-256. 1) Performance Metric: Number and percent of sample of staff personnel records that show the individual staff have passed both the criminal history records check and health care personnel registry check. **A)** Numerator = Number of individuals meeting requirements for criminal and personnel registry checks **B)** Denominator = Total number reviewed during review period	Data Sources: 1) Desktop reviews of selected cases where providers are asked to confirm that specified aides meet all professional qualification and training requirements 2) On-site review of personnel and training records Sampling: 2) Sampling Type: Stratified Random Sample of Cases 3) Strata Include: **A)** Adult Care Homes **B)** Family Care Homes **C)** Supervised Living Homes **D)** Privately-Owned Homes 4) Sampling Frequency: Monthly 5) Sample Size: **A)** Desktop Reviews: Twenty-four reviews (six cases per setting type) **B)** On-Site Record Reviews: Twelve reviews (three cases per setting type)	DMA QI Analyst and QI Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*

System Improvement:

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

Introduction

Federal regulations require that each state program approved under the §1915(i) Option have, at a minimum, systems in place to measure and improve its performance in meeting certain specified assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances, and the methodology designed to measure performances in each of six major assurance areas and associated sub-areas, are described in the state's Quality Improvement Strategy (QIS). This paper provides information to supplement this Plan and further describe the methods the state will employ to ensure that these QIS assurances are monitored and evaluated.

The North Carolina Division of Medical Assistance (DMA), as the state Medicaid Agency, retains full and final responsibility and authority for all operations conducted in this program, including services provided by other state and local agencies, contracted entities, and providers. The proposed §1915(i) Individualized Support benefit will be monitored, reviewed, and evaluated on an ongoing basis. The state will employ six different methods to monitor and continuously improve quality and compliance in each of the QIS assurance areas and the various components that pertain to each. These six methods are described below and related to the each of the assurances contained in the state's proposed §1915(i) Combined Individualized Support Quality Improvement Strategy.

Automated Systems

The DMA has developed an automated system to manage the business process of its In-Home Personal Care Services Program, including monitoring and evaluating key program administration processes, including:

1. Receiving and processing physician referrals;
2. Scheduling and conducting independent assessments and re-assessments;
3. Authorizing service levels based on assessment results;
4. Producing beneficiary/provider notifications;
5. Supporting provider choice and making provider referrals;
6. Submitting plans of care;
7. Provider reporting; and
8. Supporting requests for mediation and appeal hearings.

This system, called QiRePort, is an automated, Internet-based system that builds an integrated database that captures the information necessary to monitor and evaluate most of the assurance areas addressed in the state's QIS. DMA Quality Improvement staff will have full access to all information contained in this system and utilize this system as the principal means to provide ongoing monitoring and evaluation of all services provided and operations conducted by DMA contractors under the 1915(i) Option benefit. This system is to be expanded to include all the Individualized Support addressed under the §1915(i) Option and eventually to all the state's home and community-based services (HCBS).

QiRePort will be used to monitor the assurance areas summarized in Table 1 below.

Table 1: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the QiRePort Automated System

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-assessments	*Assurance A-1:* New admission assessments	• All assessments are automated and uploaded to QiRePort • DMA will review a random sample of new referrals from the previous month where the referral was complete and, of this number, determine how many received an independent assessment • This review will be conducted every month for new referrals processed in the previous month
	Assurance A-2: Annual re-assessments	• Annual review dates are entered into the QiRePort System • DMA will review a random sample of beneficiaries with a annual review date in the previous month and determine how many received an annual re-assessment prior to the review date • This review will be conducted every month for re-assessments processed in the previous month
	Assurance A-3: Timelines for assessments and reassessments	• DMA will determine, for both samples, how many received assessments or re-assessments, as applicable, within the required 15 business days • This review will be conducted every month for samples selected from assessments processed during the previous month
B: Service Plan (Plan of Care)	*Assurance B-1:* Complete a person-center POC for each participant	• Individualized Support Providers will be required to complete a POC based on the independent assessment and submit to DMA, or its designee, via QiRePort for review and approval • DMA will review a random sample of all POCs submitted in the previous month to determine if all requirements and criteria have been met • This review will be conducted every month for a sample of POC submitted during the previous month
	Assurance B-2: The POC is updated annually	• Providers must submit an updated POC, via QiRePort, following the annual re-assessment • DMA will look at a random sample of re-assessments conducted in the previous month to determine if an updated POC has been submitted within the required timeframe • This review will be conducted every month for a sample of POC submitted during the previous month
	Assurance B-3: Choice of provider	• The assessment protocol includes providing qualified beneficiaries with county list of providers and documenting each beneficiary's choice • No provider referral will be made if this protocol is not properly completed • This will be reviewed every month for a sample of POC submitted during the previous month
D: Recipient Health and Welfare	*Assurance D-4:* Health and safety	• Assessment for Individualized Support in private homes will include a health and safety inspection of the beneficiary's

	inspection of beneficiary's home	home • This assessment will be submitted to DMA via QiRePort • DMA will review a random sample of private in-home assessments conducted in the previous month and determine how many have included the health and safety review • This review will be conducted every month for private in-home assessments processed during the previous month

Table 1: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the QiRePort Automated System (Continued)

QIS Assurance Area	Component	DMA Monitoring
E: State Administrative Authority	*Assurance E-2:* Monitor compliance with Medicaid Clinical Coverage Policy and program administrative requirements	• Virtually all aspects of Individualized Support administration and operations are addressed by QiRePort • DMA will utilize QiRePort to review a random sample of cases processed in the previous month to determine if all clinical policies and required administrative functions were completed • This review will be conducted every month for cases processed in the previous month

Desktop Reviews and Provider Site Visits

DMA, or its designee, will establish a schedule of provider desktop reviews and site visits to conduct monitoring and review activities that require review of provider service and personnel records. DMA, or its designee, will conduct 24 desktop and 12 on-site reviews each month of provider records to monitor activities related to professional qualifications, beneficiary health and welfare, and provider service documentation.

QIS assurance areas to be addressed through provider desktop and on-site reviews are summarized in Table 2 below.

Table 2: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	*Assurance C-4:* Qualifications and training competencies for paraprofessional Individualized Support aides	Review of personnel records to determine if all employed or contracted paraprofessional aides have met the qualifications and training requirements specified in state licensure requirements for home care agencies, adult and family care homes, and supervised living homes, as appropriate
D: Recipient Health and Welfare	*Assurance D-1:* Recipient Bill of Rights	Review of beneficiary service records to determine if all beneficiaries have received a copy of their Bill of Rights that contains all required information and that the service record

		contains a signed acknowledgement by the beneficiary that he/she has receive this document
	Assurance D-2 and Assurance D-3: Incident Reports	Review of provider copies of incident reports to determine if copies were sent to DMA, Division of Health Services Regulation (DHSR) and local Department of Social Service
	Assurance D-5: Criminal background checks	Review of provider personnel records to determine if a criminal background and DHSR Health Care Personnel Registry check had been conducted on all aide and supervisory staff be employment

Table 2: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews (Continued)

QIS Assurance Area	Component	DMA Monitoring
F: State Financial Accountability	*Assurance F-2:* Claims paid are consistent with the beneficiary's service authorization, POC, and provider service r	Review of provider service records to determine if claims have been paid in accordance with the service authorization, POC, and provider service records

Use of the Medicaid Management Information Systems (MMIS)

DMA will utilize the state fiscal agent's MMIS to ensure that all QIS assurances and program requirements regarding qualified providers and financial accountability are met. QIS assurance areas to be addressed through MMIS are summarized in Table 3 below.

Table 3: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the Medicaid Managed Information System

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	*Assurance C-1:* Services provided to beneficiaries in private homes are provided by home care agencies licensed by DHSR and enrolled with Medicaid as a home care provider	Quarterly random samples of paid claims will be reviewed to determine how many claims were denied because the provider was not an enrolled Medicaid provider of home care services
	Assurance C-2: Services provided to beneficiaries in adult and family care homes are provided by adult and family care homes licensed by DHSR and	Quarterly random samples of paid claims will be reviewed to determine how many were denied because the provider was not an enrolled Medicaid provider of adult care home services

	enrolled with Medicaid as an adult or family care home provider	
	Assurance C-3: Services provided to beneficiaries in supervised living homes are provided by facilities licensed by DHSR and Enrolled with Medicaid as a supervised living home	Quarterly random samples of paid claims will be reviewed to determine how many were denied because the provider was not an enrolled Medicaid provider of supervised living services

Contracts and Memorandums of Agreement

DMA will utilize contractual agreements with private entities and Memorandums of Agreements with other state, local, and regional agencies to ensure that the state complies with its QIS assurances and maintains appropriate management oversight of program operations. DMA monitors all contracts and memorandums of agreement according to the State's performance based contracting requirements.

QIS assurance areas to be addressed through contracts and Memoranda of Agreement are summarized in Table 4 below.

Table 4: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Contracts and Memorandums of Agreement

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-Assessments	*Assurance A-4:* Assessments conducted by qualified professionals	• Contracts with entities providing assessments will be required to meet specified professional qualifications for assessors • Assessor qualifications will be reviewed by DMA • DMA will approve assessor orientation and training programs • DMA will specify and approve contractor or quality assurance procedures for monitoring and evaluating the validity and reliability of assessments
E: State Administrative Authority	*Assurance E-1:* Contractual Agreements	All contracts for services provided under the (i) Option will establish DMA (Medicaid) authority and management oversight over all program services and operations
	Assurance E-1: Memorandums of Agreement	All Memoranda of Agreements with state, regional, and local agencies will establish DMA (Medicaid) authority and management oversight over all program services and operation

Recipient Surveys

DMA will survey Individualized Support beneficiaries on an ongoing basis to determine their satisfaction with the quality of care and quality of service provided to them under this benefit. QIS assurance areas to be addressed through a Recipient Satisfaction Survey are summarized in Table 5

below.

Table 5: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing a Recipient Satisfaction Survey

QIS Assurance Area	Component	DMA Monitoring
C: Qualified Providers	*Assurance C-5:* Determine the level of satisfaction with services furnished by provider agencies and direct care staff	DMA will conduct a program participant satisfactions survey each time an annual re-assessment, change of status re-assessment review, or change of provider request is processed.

Quality Improvement Staff

DMA will develop an operational budget for the §1915(i) Option Individualized Support Benefit that will include funding for a Program Manager and QI Analyst. Contractors will also be required to designate a QI Manager to participate in the QIS and Continuous Quality Improvement Programs conducted under this benefit. The Program Manager and QI Analyst will review all performance metrics on a month-to-month basis and be responsible for initiating any corrective action plans required to remediated identified problems or deficiencies.