

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

Administration and Operation

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

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

Personal Assistance Services

2. Statewide. *(Select one):*

<input checked="" type="radio"/>	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewide 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. <i>(Specify the areas to which this option applies):</i>

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

<input checked="" type="radio"/>	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 <i>(select one)</i> :	
<input checked="" type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :	Division of Medical Assistance, North Carolina Department of Health and Human Services
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any – NO LIMITS	<input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

Items 1, 3, 5, 6 (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 1915(i) services. DMA retains full and final responsibility and authority for all operations conducted in this program 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 7 & 8 (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 11 (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.

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).
(Specify target group(s)):

Target Population	Group A: Individuals with Physical Disabilities	Group B: Adults with MI, MR/DD, and Dementia Diagnoses	Group C: At-Risk Elderly
Population Definition Age, Diagnoses, and Physician*- Documented Functional Limitations, Need for Caregiver Availability, and Risks	Medicaid recipients of all ages with a documented medical condition or physical disability (diagnosis) that a physician attests limits the person’s ability to independently perform activities of daily living (ADLs).	Medicaid recipients age 18 or older with a documented MI, MR/DD, or dementia diagnosis that a physician attests limits the person’s ability to independently perform ADLs. Members of this target population also must require 24-hour caregiver availability, as attested by the physician.	Medicaid recipients 65 years of age and older with physician-documented limitations in functional abilities and risk of falls, malnutrition, skin breakdown, or complications from medication non-compliance.
Eligibility Criteria Established by an independent functional assessment of the person’s ADL and IADL needs	Any of the following: 1. Unmet need for hands-on assistance with three (3) ADLs, or 2. Unmet need for hands-on assistance with two (2) ADLs, one of which requires extensive or greater assistance, or 3. Unmet need for hands-on assistance with two (2) ADLs <u>and</u> assistance with Meal Preparation or Medication Management.	Any of the following: 1. Unmet need for hands-on assistance with two (2) ADLs, 2. Unmet need for hands-on assistance with one (1) ADL <u>and</u> set-up/supervision assistance with two (2) additional ADLs, 3. Unmet need for hands-on assistance with one (1) ADL <u>and</u> assistance with Meal Preparation or Medication Management. 4. Unmet need for set-up/supervision assistance with two (2) ADLs <u>and</u> assistance with Meal Preparation or Medication Management.	Either of the following: 1. Unmet need for hands-on assistance with two (s) ADLs, or 2. Unmet need for hands-on assistance with one (1) ADL <u>and</u> assistance with Meal Preparation or Medication Management.

* "Physician" may be the individual’s primary care or attending 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	50,000

- 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):*

<input type="checkbox"/>	The State does not provide State plan HCBS to the medically needy.
<input checked="" type="checkbox"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="checkbox"/>	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.
<input checked="" type="checkbox"/>	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):*

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i> 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 recipient's provider of choice. If a recipient or family doesn't have a provider of choice, the assessor will give the

recipient a list of providers in the recipient’s geographic area.

Personal Assistance 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 PAS population undergoes an independent assessment conducted by an independent assessor (qualified RN) using a standardized assessment tool that is used to determine program eligibility and service level. Maintaining the Patient Centered focus, the provider agency RN incorporates the recipient 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 PAS program eligibility criteria. Level of assistance needed is scored as supervision/set up; limited hand-on; extensive; or total/full dependence. A crosswalk is provided below demonstrating comparability between assessment tool dimensions and 1915(i) PAS program functional eligibility criteria.

Current In-Home Assessment	Independent Assessor RN meeting qualifications and competencies	Proposed 1915(i) functional eligibility criteria	Independent Assessor SW or RN meeting qualifications and competencies
Bathing	<input checked="" type="checkbox"/>	Bathing	<input checked="" type="checkbox"/>
Dressing	<input checked="" type="checkbox"/>	Dressing	<input checked="" type="checkbox"/>
Mobility (Ambulation and Transfer) ADL	<input checked="" type="checkbox"/>	Mobility	<input checked="" type="checkbox"/>
Toileting ADL	<input checked="" type="checkbox"/>	Toileting	<input checked="" type="checkbox"/>
Eating ADL	<input checked="" type="checkbox"/>	Eating	<input checked="" type="checkbox"/>
Meal Preparation	<input checked="" type="checkbox"/>	Meal Preparation	<input checked="" type="checkbox"/>
Medication Assistance	<input checked="" type="checkbox"/>	Medication Assistance	<input checked="" type="checkbox"/>

The state asserts that all In-Home recipients who qualified on the basis of an independent assessment conducted within the 12 months prior to implementation of the 1915(i) PAS program 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) PAS program. Annual reassessment will be required of all recipients to determine continuing eligibility and service levels, and all recipients transitioned on the basis of a previous assessment under the In-Home Care program will be reevaluated within 12 months of the previous assessment. If a recipient 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 PAS services will continue. The State will use the standardized assessment tool or a comparable alternative to assess all new program referrals and continuing recipients post-implementation.

The independent assessor must meet the requirements of the NC DHHS job classification of Public Health Nurse I, II or higher or Social Worker I, II or higher. These assessors may be NC employees or contractors. Contractors will meet the qualifications for an independent assessor and be capable of conducting the independent assessment and /or re-evaluations for all recipients (new and existing) under the 1915(i). NC maintains ultimate oversight of all independent assessors through contract performance measures, approving assessor orientation and training, and approval of contractors’ quality assurance procedures for monitoring and evaluating the validity and reliability of assessments.

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 the 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.

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	Group A: Individuals with Physical Disabilities	Group B: Adults with MI, MR/DD, and Dementia Diagnoses	Group C: At-Risk Elderly
Population Definition Age, Diagnoses, and Physician-Documented Functional Limitations, Need for Caregiver Availability, and Risks	Medicaid recipients of all ages with a documented medical condition or physical disability (diagnosis) that a physician attests limits the person’s ability to independently perform activities of daily living (ADLs).	Medicaid recipients age 18 or older with a documented MI, MR/DD, or dementia diagnosis that a physician attests limits the person’s ability to independently perform ADLs. Members of this target population also must require 24-hour caregiver availability, as attested by the physician.	Medicaid recipients 65 years of age and older with physician-documented limitations in functional abilities and risk of falls, malnutrition, skin breakdown, or complications from medication non-compliance.
Eligibility Criteria Established by an independent functional assessment of the person’s ADL and IADL needs	Any of the following: 1. Unmet need for hands-on assistance with three (3) ADLs, or 2. Unmet need for hands-on assistance with two (2) ADLs, one of which requires extensive or greater assistance, or 3. Unmet need for hands-on assistance with two (2) ADLs <u>and</u> assistance with Meal Preparation or Medication Management.	Any of the following: 1. Unmet need for hands-on assistance with two (2) ADLs, 2. Unmet need for hands-on assistance with one (1) ADL <u>and</u> set-up/supervision assistance with two (2) additional ADLs, 3. Unmet need for hands-on assistance with one (1) ADL <u>and</u> assistance with Meal Preparation or Medication Management. 4. Unmet need for set-up/supervision assistance with two (2) ADLs and assistance with Meal Preparation or Medication Management	Either of the following: 1. Unmet need for hands-on assistance with two (2) ADLs, or 2. Unmet need for hands-on assistance with one (1) ADL <u>and</u> assistance with Meal Preparation or Medication Management.

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 I State plan HCBS needs-based eligibility criteria	Column II NF (& NF LOC waivers)	Column III ICF/MR (& ICF/MR LOC waivers)	Column III Applicable Hospital *LOC (& Hospital LOC waivers)
<p>Needs-based eligibility criteria are defined entirely by the individual's needs for hands-on and supervision level assistance with qualifying ADLs and IADLs, as specified in item # 4 above.</p>	<p>The following criteria are not intended to be the only determinants of the resident's or recipient's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or recipient's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives. All professional services that are provided to the resident or recipient to maintain, monitor, and/or enhance the resident's or recipient's level of health must be addressed in the medical records and reflected on the medical eligibility assessment form.</p> <p>Qualifying Conditions: Conditions that are considered when assessing a recipient for nursing facility level of care include</p>	<p>In order to be Medicaid-certified at an ICF/MR level of care, an individual must meet the following criteria:</p> <ol style="list-style-type: none"> 1. Require active treatment necessitating the ICF/MR level of care; and 2. Have a diagnosis of mental retardation, Intelligence Quotient (IQ) test results indicating mental retardation, or a condition that is closely related to mental retardation. <ol style="list-style-type: none"> a. Mental retardation is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18. b. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets ALL of the following conditions: <ol style="list-style-type: none"> i. is attributable to: <ol style="list-style-type: none"> (a) Cerebral palsy, epilepsy; or 	<p>The State's Community Alternatives Program for Children (CAP/C) is the only 1915(c) waiver program that includes hospital level of care; hospital level of care criteria for this waiver are as follows: In addition to meeting nursing facility level of care as defined in Column III, hospital level of care requires that the recipient meet at least one of the following additional criteria:</p> <ol style="list-style-type: none"> 1. ventilator dependency, for all or part of day 2. tracheostomy requiring suctioning more often than every four hours 3. oxygen dependency when the flow rate requires adjustments based on oxygen saturation levels 4. PRN medications, excluding routine topical medications such as those used for diaper rash, administered more often than every four hours and requiring

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	<p>the following:</p> <p>a. Need for services that, by physician judgment, require</p> <ol style="list-style-type: none"> 1. a registered nurse for a minimum of 8 hours daily and 2. other personnel working under the supervision of a licensed nurse <p>b. Need for daily licensed nurse observation and assessment of resident needs</p> <p>c. Need for administration and/or control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 13O.0202, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for supervision)</p> <p>d. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible; such</p>	<p>(b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and;</p> <p>ii. The related condition manifested before age 22; and</p> <p>iii. Is likely to continue indefinitely; and</p> <p>iv. Have mental retardation or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:</p> <ol style="list-style-type: none"> (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 	<p>the assessment, judgment, and intervention of a nurse</p> <ol style="list-style-type: none"> 5. more than two unplanned hospitalizations within the last year, or more than three total hospitalizations within the last year 6. interventions that occur at least every two hours AND require the scope of practice of an LPN or RN.
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	<p>measures may include, but are not limited to, the following:</p> <ol style="list-style-type: none"> 1. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transfer/ambulation) 2. Using preventive measures and devices, such as positioning and alignment, range of motion, hand rolls, and positioning pillows, to prevent or retard the development of contractures 3. Training in ambulation and gait, with or without assistive devices <p>e. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician</p> <p>f. Nasogastric/gastrostomy tubes: requiring supervision and observation by licensed nurses</p> <ol style="list-style-type: none"> 1. Tube with flushes 2. Medications administered through the tube 3. Supplemental bolus feedings <p>g. Respiratory therapy: oxygen as a temporary or intermittent therapy or</p>	<p>new behaviors, perceptions and information, and to apply experiences to new situations)</p> <p>(d) Mobility (ambulatory, semi-ambulatory, non-ambulatory)</p> <p>(e) Self-direction (managing one’s social and personal life and ability to make decisions necessary to protect one’s life)</p> <p>(f) Capacity for independent living (age-appropriate ability to live without extraordinary assistance).</p> <p>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.</p>	
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	<p>for residents who receive oxygen therapy continuously as a component of a stable treatment plan</p> <ol style="list-style-type: none"> 1. Nebulizer usage 2. Pulse oximetry 3. Oral suctioning <p>h. Wounds and care of decubitus ulcers or open areas</p> <p>i. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan</p> <p>j. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan</p> <p>k. Diabetes, when daily observation of dietary intake and/or medication administration is required for proper physiological control</p> <p>Conditions That May Justify a Nursing Facility Level of Care</p> <p>The following conditions may justify nursing facility level of care placement:</p> <ol style="list-style-type: none"> a. Need for teaching and counseling related to a disease process, disability, diet, or medication b. Adaptive programs: training the resident to reach his or her maximum potential (such as 		
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	<p>bowel and bladder training or restorative feeding); documentation must include the purpose of the resident's participation in the program and the resident's progress</p> <p>c. Ancillary therapies: supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts</p> <p>d. Injections: requiring administration and/or professional judgment by a licensed nurse</p> <p>e. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction</p> <p>f. Psychosocial considerations: psychosocial condition of each resident will be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care; factors to consider along with the resident's medical needs include</p> <p>1. Acute psychological</p>		
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	<p>symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician’s orders or progress notes and/or by nursing or therapy notes)</p> <ol style="list-style-type: none"> 2. Age 3. Length of stay in current placement 4. Location and condition of spouse 5. Proximity of social support 6. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer) <p>g. Blindness</p> <p>h. Behavioral problems such as</p> <ol style="list-style-type: none"> 1. Wandering 2. Verbal disruptiveness 3. Combativeness 4. Verbal or physical abusiveness 5. Inappropriate behavior (when it can be properly managed at the nursing facility level of care) <p>i. Frequent falls</p> <p>j. Chronic recurrent medical problems that require daily observation by licensed personnel for</p>		
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	prevention and/or treatment		
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*Long Term Care/Chronic Care Hospital

(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):*

Adult Care Homes: “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: 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. 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.

The following home and community living standards must be met by all facilities. They must be applied to all residents 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 standards or rights. Residents 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.

- Telephone Access
 - Must be available 24/7/365

- Operation Assistance must be available if Necessary
- Must be private
- Residents are permitted to have and maintain personal phones in their rooms
- Visitors
 - Must be allowed at any time 24/7/365
 - Does not require facility approval (although facility may require visitors to sign in or notify the facility administrator that they are in the facility)
 - Must not have conduct requirements beyond respectful behavior toward other residents
- Living Space
 - Must have no more than 2 residents to a room
 - If two individuals must share a room, they will have choice as to who their roommate is; under no circumstance will individuals be required to room together if either of them objects to sharing a room with the other
 - Must have the ability to work with the facility to achieve the closest optimal roommate situations
 - Must have the ability to lock the rooms
 - Must be allowed to decorate and keep personal items in the rooms
 - Residents must be able to come and go at any hour
 - Residents must have an individual personal lockable storage space available at any time.
 - Must be able to file anonymous complaints
 - Residents must be permitted to have personal appliances and devices in their rooms
- Service Customization
 - Residents must be given maximum privacy in the delivery of their Services
 - Residents must be provided choice(s) in the structure of their Service delivery (services and supports, and from where and whom)
 - Include the individual in care planning process as well as people chosen by the individual to attend care plan meetings
 - Provide the appropriate support(s) to ensure that the individual has an active role in directing the process
 - Person centered planning process must be at convenient locations and times for the individuals to attend
 - Ensure there are opportunities for the person centered plan are updated on a continuous basis
- Kitchen
 - Must be accessible 24/7/365
 - Must have accessible appliances
 - Residents must have input on food options provided
 - Residents must be allowed to choose who to eat meals with including the ability to eat alone if desired
- Group Activities
 - Residents must be given the choice of participating in facility's recreational activities
 - Residents must be allowed to chose who to participate in recreational activities with
- Community Activities
 - Residents must be given the ability to take part in community activities of their choosing
 - Residents must be encouraged to remain active in their community
 - Residents must not be restricted from participating in community activities of their choosing
- Community Integration
 - Would anyone view this residence as part of the community?

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 as defined in 42 CFR §441.568 ;
 - 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 as required in 42 CFR §441.565;
 - 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;
 - Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
 - 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 Inter-RAI Community Health 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 Personal Assistance 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 recipient 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.

Personal Assistance 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 Personal Assistance 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.

The Automated Web-based Tool which coordinates the 1915(i) Independent Assessment and the 1915 (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 client and others involved in the care planning process. Clients 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 client is the sole authority when making decisions unless a responsible party or guardian has been given authority to make decisions on the applicant/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 recipient under 21 years of age is a request for EPSDT services. The decision to approve or deny the request will be based on the recipient’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 recipients 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 client with a list of all enrolled Medicaid providers of 1915(i) services within the client’s geographic area. The client will be asked if any preferences exist such as a certain county or location. The IAE also provides clients 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)*:

<input checked="" type="checkbox"/>	Medicaid agency via web-based assessment/care planning system	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other <i>(specify)</i> :	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:	Personal Assistance Services
Service Definition (Scope):	
<p>Personal Assistance provided under this 1915(i) program consists of assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for three distinct target populations: individuals with physical disabilities; adults with a diagnosis of mental illness, mental retardation/developmental disability, or dementia; and elderly individuals with functional limitations and risks. ADLs, for the purposes of this program, are defined as eating, dressing, bathing, toileting, and mobility. Covered IADLs are meal preparation, medication assistance, and basic home management tasks that are directly related to the qualifying ADLs and essential to the recipient's care at home. Personal Assistance also covers essential errands that are critical to maintaining the recipient's health and safety. Essential errands, for the purposes of this program, are defined as medication pick-up, off-site laundry, and grocery pick-up.</p> <p>Personal Assistance is provided in the recipient's home by paraprofessional aides employed by licensed home care agencies or in licensed adult care homes, or supervised living homes by home staff. For the purposes of this program, the recipient's home may be a private living arrangement or 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 mental retardation, developmental disabilities or mental illness.</p> <p>The amount of service provided is based on an assessment conducted by an independent entity to determine the individual's ability to perform the qualifying ADLs and IADLs. 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.</p>	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	
<p>The following additional requirements must be met for an individual to receive the service <u>in his or her private living arrangement</u>:</p> <ol style="list-style-type: none"> 1. The home environment is safe and free of health hazards for the recipient and PAS 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 <i>(chose each that applies)</i> :			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> : Adults 21 years of age and older may be authorized for no more than 80 hours of service per month. Authorized services for adults 21 years of age and older who qualify for services with unmet need for hands-on assistance with one or zero ADLs are limited to one hour per day of unmet need for assistance.		
	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 personal assistance hours in adult care homes do not cover basic meal preparation or errands services that duplicate state- and county-funded room and board services.		
	Limits as described above in tiers 1-4.		
<input checked="" type="checkbox"/>	Medically needy <i>(specify limits)</i> : Same as above.		
	Limits as described above in tiers 1-4.		
Provider Qualifications <i>(For each type of provider. Copy rows as needed)</i> :			
Provider Type <i>(Specify)</i> :	License <i>(Specify)</i> :	Certification <i>(Specify)</i> :	Other Standard <i>(Specify)</i> :
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 <u>all</u> adult care home staff.

TN:

Effective:

Approved:

Supersedes:

<p>Supervised Living</p>	<p>NC General Statute 122-C and 10A NC Administrative Code 27G 5600, Supervised Living Facilities, designated as type A and C homes</p>		<ul style="list-style-type: none"> •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
<p>Home Care Agencies</p>	<p>Licensed under NC Administrative Code Title 10A, Chapter 13, Subchapter J</p>		<p>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.</p>
<p>Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as</i></p>			

TN:

Effective:

Approved:

Supersedes:

<i>needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Adult Care Homes	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses adult care homes.	Annually
Supervised Living	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses supervised living homes.	Annually
Home Care Agencies	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses supervised living homes.	Annually
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> 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):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	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.
<input type="radio"/>	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. <i>(Specify criteria):</i>

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):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	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. <i>(Specify the areas of the State affected by this option):</i>
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	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one):* N/A

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	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):*

<input checked="" type="checkbox"/>	The State does not offer opportunity for participant-employer authority.
<input type="checkbox"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	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.
<input type="checkbox"/>	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):*

<input checked="" type="checkbox"/>	The State does not offer opportunity for participants to direct a budget.
<input type="checkbox"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(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):</i>
	Expenditure Safeguards. <i>(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):</i>
	N/A

Quality Improvement Strategy

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

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

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

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	reviewed where the assessment was conducted by a qualified assessor B) Denominator = Number of cases reviewed in the review period	for previous month based on the 95% confidence level Who Aggregates and Analyzes: DMA QI Analyst				
	Assurance 5: All PAS Providers accepting new referrals for PAS will complete a person-centered POC that addresses the assessed needs of the PAS 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 PAS Providers will complete an updated person-centered POC following an annual re-assessment within 20 business days of the reassessment 1) Performance Metric: 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	Data Source: QiRePort Sampling: 1) Sample Type: Random Sample 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: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	reviewed during review period					
	<p>Assurance 7: Each POC shall document participant choice of provider</p> <p>1) Performance Metric: Total number and percent of plans of care that document participant choice of provider</p> <p>A) Numerator = Number of participants reviewed with a plan of care that documents provider choice</p> <p>B) Denominator = Number of participants reviewed during review period</p>	<p>Data Source: QiRePort</p> <p>Sampling:</p> <p>1) Sample Type: Random sample of plans of care submitted in previous month</p> <p>2) Sampling Frequency: Monthly</p> <p>3) Sample Size: Determined each month for previous month based on the 95% confidence level</p>	IT Support Vendor	Monthly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses Individual Issues: PAC QI Manager</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Monthly
Providers meet required qualifications.	<p>Assurance 1: All PAS furnished to qualified recipients 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 PAS in POHs.</p> <p>1) Performance Metric: Number and percent of home care agencies that received appropriate licensure by the DHSR prior to the provision of program services to participants in the POH setting</p> <p>A) Numerator = Number of home care agencies providing services that received appropriate licensure by DHSR prior to</p>	<p>Data Source: MMIS report</p> <p>Sampling:</p> <p>1) Sampling Type: Random sample of claims filed by home care agencies to determine how many were denied because they were not enrolled providers</p> <p>2) Sampling Frequency: Quarterly</p> <p>3) Sample Size: Determined each quarter for claims filed by home care agencies for services to recipients in the POH setting for previous quarter based on the 95% confidence level</p>	DMA QI Analyst	Quarterly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses Individual Issues: PAC QI Manager</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Quarterly

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	providing services to program participants B) Denominator = All home care agencies submitting claims during the review period					
	Assurance 2: All PAS furnished to qualified recipients 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 program services A) Numerator = Number of adult and family care homes that received appropriate licensure by DHSR prior to providing services to program 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 PAS 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
	Assurance 3: All PAS furnished to qualified recipients in Supervised Living Homes that received appropriate licensure by DHSR prior to provision of program services. 1) Performance Metric: Number and percent of SLHs	Data Source: MMIS reports Sampling: 1) Sample Type: Random sample of claims filed by supervised living homes to determine how many	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: DMA QI Analyst Who Tracks	Quarterly

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	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 program participants B) All supervised living homes submitting claims during the review period	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 PAS provided to qualified recipients in the SLH for previous quarter based on the 95% confidence level			Remediation: DMA QI Analyst	
	Assurance 4: All PAS 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 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	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 C) Supervised Living Homes D) Privately-Owned Homes 3) Sampling Frequency: Monthly 4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six	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 <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
		cases for each of the program settings) B) On-Site Record Reviews: Twelve reviews (three cases for each of the program settings)				
	Assurance 5: The state shall determine participants' satisfaction with the quality of care and quality of personal care services furnished by the agency or home and the direct care staff. 1) Performance Metric: Number and percent of recipients 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 PAS 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 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	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 <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
The SMA retains authority and responsibility for program operations and oversight.	<p>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.</p> <p>1) Performance Metrics: Number and percent of contractors with performance-based agreements establishing DMA authority and responsibility for program operations and oversight.</p> <p>A) Numerator = Number of agreements reviewed that fulfill this requirement</p> <p>B) Total reviewed during review period</p>	<p>Data Source: Program files and documents</p> <p>1) Written performance-based agreements; and</p> <p>2) Performance reviews</p> <p>Sampling:</p> <p>1) Sample Type: One hundred percent review of all contracts executed in review period</p> <p>2) Sampling Frequency: Quarterly</p> <p>3) Sample Size: All contracts, other agreements, and performance reviews</p>	DMA QI Analyst	Quarterly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses DMA QI Analyst</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Quarterly
	<p>Assurance 2: The North Carolina Division of Medical Assistance shall monitor all clinical policy requirements and program administrative functions on an ongoing basis using an automated program management system.</p> <p>1) Performance Metrics: Total and percent of cases meeting program standards for:</p> <p>A) Compliance with Medicaid Clinical Coverage Policy</p>	<p>Data Source: QiRePort</p> <p>Sampling:</p> <p>2) Sample Type: Random</p> <p>3) Sampling Frequency: Monthly</p> <p>4) Sample Size: Determined each month for the total program enrollment based on the 95% confidence level for:</p>	Program IT Contractor	Monthly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses DMA QI Analyst</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Monthly

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

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

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	service records reviewed that contain: <ul style="list-style-type: none"> i) Information on reporting incidents and submitting complaints; and ii) A signed and dated acknowledgement that recipient 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	4) Sample Size: <ul style="list-style-type: none"> A) Desktop Reviews: Twenty-four reviews (six cases per program setting) B) On-Site Record Reviews: Twelve reviews (three cases per program setting) 				
	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 <ul style="list-style-type: none"> 1) Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe <ul style="list-style-type: none"> A) Numerator = Number cases reviewed that met reporting requirement B) Denominator = Total number reviewed during review period 	Data Source: Provider service records Sampling: <ul style="list-style-type: none"> 1) Sampling Type: Stratified Random Sample of Cases 2) Strata Include: <ul style="list-style-type: none"> A) Adult Care Homes B) Family Care Homes C) Privately-Owned Homes 3) Sampling Frequency: Monthly 4) Sample Size: <ul style="list-style-type: none"> A) Desktop Reviews: Twenty-four reviews (six cases per program setting) B) On-Site Record Reviews: 	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 <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
		Twelve reviews (three cases per program setting)				
	<p>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</p> <p>1) Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe</p> <p>A) Numerator = Number cases reviewed that met reporting requirement</p> <p>B) Denominator = Total number reviewed during review period</p>	<p>Data Source: Provider service records</p> <p>Sampling:</p> <p>1) Sampling Type: Stratified Random Sample of Cases</p> <p>2) Strata Include:</p> <p>A) Supervised Living Homes</p> <p>3) Sampling Frequency: Monthly</p> <p>4) Sample Size:</p> <p>A) Desktop Reviews: Twenty-four reviews (six cases per program setting)</p> <p>B) On-Site Record Reviews: Twelve reviews (three cases per program setting)</p>	Providers	Monthly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses Individual Issues: PAC QI Manager</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Monthly
	<p>Assurance 4: Personal care assessments completed in the recipient's home shall include an inspection of the home and identification of any health or safety risks.</p> <p>1) Performance Metric: Number and percent of in-home assessments that include a home health and safety inspection</p> <p>A) Numerator = Number of assessments that included a home health and safety inspection</p> <p>B) Denominator = Total number reviewed during review period</p>	<p>Data Source: QiRePort</p> <p>Sampling:</p> <p>1) Sample Type: Random sample</p> <p>2) Sampling Frequency: Monthly</p> <p>3) Sample Size: Determined each month for the previous month based on the 95% confidence level</p>	Program IT Contractor	Monthly	<p>Who Aggregates and Analyzes: PAC QI Manager</p> <p>Who Addresses Individual Issues: DMA QI Analyst</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Monthly

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>of Analysis and Aggregation</i>
	<p>Assurance 5: All aide and supervisory staff employed or under contract to the PAS 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.</p> <p>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.</p> <p>A) Numerator = Number of individuals meeting requirements for criminal and personnel registry checks</p> <p>B) Denominator = Total number reviewed during review period</p>	<p>Data Sources:</p> <p>1) Desktop reviews of selected cases where providers are asked to confirm that specified aides meet all professional qualification and training requirements</p> <p>2) On-site review of personnel and training records</p> <p>Sampling:</p> <p>2) Sampling Type: Stratified Random Sample of Cases</p> <p>3) Strata Include:</p> <p>A) Adult Care Homes</p> <p>B) Family Care Homes</p> <p>C) Supervised Living Homes</p> <p>D) Privately-Owned Homes</p> <p>4) Sampling Frequency: Monthly</p> <p>5) Sample Size:</p> <p>A) Desktop Reviews: Twenty-four reviews (six cases per program setting)</p> <p>B) On-Site Record Reviews: Twelve reviews (three cases per program setting)</p>	DMA QI Analyst and QI Contractor	Monthly	<p>Who Aggregates and Analyzes: DMA QI Analyst</p> <p>Who Addresses Individual Issues: PAC QI Manager</p> <p>Who Tracks Remediation: DMA QI Analyst</p>	Monthly

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) Combined PAS Program 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 PAS 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 recipient/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 (i) Option program. This system is to be expanded to include all the PAS 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 Combined PAS Program QIS Monitoring Activities Utilizing the QiRePort Automated System

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-assessments	<i>Assurance A-1:</i> New admission assessments	<ul style="list-style-type: none"> 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
	<i>Assurance A-2:</i> Annual re-assessments	<ul style="list-style-type: none"> Annual review dates are entered into the QiRePort System DMA will review a random sample of recipients 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
	<i>Assurance A-3:</i> Timelines for assessments and reassessments	<ul style="list-style-type: none"> 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)	<i>Assurance B-1:</i> Complete a person-center POC for each program participant	<ul style="list-style-type: none"> PAS 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
	<i>Assurance B-2:</i> The POC is updated annually	<ul style="list-style-type: none"> 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
	<i>Assurance B-3:</i> Choice of provider	<ul style="list-style-type: none"> The assessment protocol includes providing qualified recipients with county list of providers and documenting each recipient'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	<i>Assurance D-4:</i> Health and safety inspection of recipient's home	<ul style="list-style-type: none"> Assessment for PAS in private homes will include a health and safety inspection of the recipient's 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 <ul style="list-style-type: none"> • This review will be conducted every month for private in-home assessments processed during the previous month
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Table 1: Summary of §1915(i) Option Combined PAS Program QIS Monitoring Activities Utilizing the QiRePort Automated System (Continued)

QIS Assurance Area	Component	DMA Monitoring
E: State Administrative Authority	<i>Assurance E-2:</i> Monitor compliance with Medicaid Clinical Coverage Policy and program administrative requirements	<ul style="list-style-type: none"> • Virtually all aspects of PAS 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, recipient 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 Combined PAS Program QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	<i>Assurance C-4:</i> Qualifications and training competencies for paraprofessional PAS 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	<i>Assurance D-1:</i> Recipient Bill of Rights	Review of recipient service records to determine if all recipients 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 recipient that he/she has receive this document
	<i>Assurance D-2 and Assurance D-3:</i>	Review of provider copies of incident reports to determine if copies were sent to DMA, Division of Health Services

	Incident Reports	Regulation (DHSR) and local Department of Social Service
	<i>Assurance D-5:</i> 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 before employment

Table 2: Summary of §1915(i) Option Combined PAS Program QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews (Continued)

QIS Assurance Area	Component	DMA Monitoring
F: State Financial Accountability	<i>Assurance F-2:</i> Claims paid are consistent with the recipient’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 Combined PAS Program QIS Monitoring Activities Utilizing the Medicaid Managed Information System

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	<i>Assurance C-1:</i> Services provided to recipients 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
	<i>Assurance C-2:</i> Services provided to recipients in adult and family care homes are provided by adult and family care homes licensed by DHSR and enrolled with Medicaid as an adult or family care home provider	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
	<i>Assurance C-3:</i>	Quarterly random samples of paid claims will be reviewed to

	Services provided to recipients in supervised living homes are provided by facilities licensed by DHR and Enrolled with Medicaid as a supervised living home	determine how many were denied because the provider was not an enrolled Medicaid provider of supervised living services
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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 Combined PAS Program QIS Monitoring Activities Utilizing Contracts and Memorandums of Agreement

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-Assessments	<i>Assurance A-4:</i> Assessments conducted by qualified professionals	<ul style="list-style-type: none"> • 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	<i>Assurance E-1:</i> 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
	<i>Assurance E-1:</i> 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 program participants on an ongoing basis to determine their satisfaction with the quality of care and quality of service provided to them under this program. QIS assurance areas to be addressed through a Recipient Satisfaction Survey are summarized in Table 5 below.

Table 5: Summary of §1915(i) Option Combined PAS Program QIS Monitoring Activities Utilizing a Recipient Satisfaction Survey

QIS Assurance Area	Component	DMA Monitoring
C: Qualified Providers	<i>Assurance C-5:</i> 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 Combined PAS Program 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 program. 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 remediate identified problems or deficiencies.

Methods and Standards for Establishing Payment Rates

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

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input checked="" type="checkbox"/>	<p>Personal Assistance Services</p> <p>Personal Assistance Services are provided in private residences or in adult care home or supervised living home when prescribed in accordance with a plan of treatment and provided by a qualified person.</p> <p>Payment for Personal Assistance Services will be defined in the State Plan, Attachment 4.19-B, Section 23, Page 6.</p> <p>These services will be reimbursed based on provision of service in fifteen (15) minute increments of care as defined by State Plan, Attachment 3.1-A.1, Page 19 <i>(State Plan section will be changed accordingly)</i>.</p> <p>The fifteen-minute unit rate will be established by using a combination of cost data obtained from the provider community of both the home based providers and adult care home or supervised living home providers. This rate will be a prospective rate and shall not be subject to any cost settlements.</p>

	<p>Except as otherwise noted in the plan, the state-developed fee schedule rate is the same for both governmental and non-governmental providers of Personal Assistance Services. This rate is published at http://www.ncdhhs.gov/dma/fee/index.htm. Subsequent to the initial effective date of the Personal Assistance Services rate, this rate shall be adjusted annually using the Medicare Home Health Agency market basket index unless otherwise noted on Supplement 1, page 1b to the 4.19-B section.</p>	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)