

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4) (5) and Section 441.710(a) (1) (2))

North Carolina Vision

North Carolina supports serving individuals with disabilities in the least restrictive and most integrated settings possible, based on what is clinically appropriate as defined by the individual's person-centered planning process. Through the planning process, the Department believes that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards. These settings will vary depending upon individual preferences and supports needed to live in the community.

Our planning process to ensure North Carolina's compliance with Centers for Medicare and Medicaid Services (CMS) Home and Community Based Standard (HCBS) rules will actively engage our beneficiary and provider stakeholders. We will create a plan that supports individuals through a person-centered process that builds upon our already existing system and supports providers to ensure compliance with rules. *

*Adopted July, 2014 by the Secretary of the North Carolina Department of Health and Human Services.

Purpose

In January 2014, the Centers for Medicaid and Medicare Services (CMS) published the final Home and Community Based Services rules to ensure that individuals receiving long-term services and supports through (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to the benefit of community living and the opportunity to receive services in the most integrated setting possible. Furthermore, CMS denotes that the intent of this rule is to enhance the quality of HCBS and provide protections to participants. This rule was effective March 2014.

North Carolina's transition plan for waiver beneficiaries provides individuals access to their communities. Among the benefits are opportunities to seek employment and to work competitively within an integrated work force, to select services and supports and who provides these, and to have the same access to community life as others. It is our intention that the unique life experiences of and personal outcomes sought by each individual will inform his or her home and community-based services and supports and that measures of overall systems performance will reflect this commitment. The State's plan will clearly describe the actions that will be taken to ensure, by 2018, initial and, on-going compliance with the HCBS Community Rule. The State will work in partnership with and support Local Management Entities-Managed Care Organizations (LME-MCOs) and Local Lead Agencies¹ in meeting the HCBS Community Rule's intent; however, the State is ultimately responsible for the review, modification, and monitoring of

¹ All references to "Local Lead Agency" include Case Management Entities for the CAP-DA and CAP-Choice waivers.

any laws, rules, regulations, standards, policies agreements, contracts and licensing requirements necessary to ensure that North Carolina's HCBS settings comport with the Rule requirements.

The federal citations for the main requirements of the rule are 42 CFR 441.301(c)(4)(5), and Section 441.710(a)(1)(2). More information on the rule can be found on the CMS website at: <http://Medicaid.gov>.

Rule Requirements Home and Community-Based Setting Requirements:

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

Provider Owned or Controlled Residential Settings – Additional Requirements:

- Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the State, county, city or other designated entity;
- Provide privacy in sleeping or living unit;
- Provide freedom and support to control individual schedules and activities and to have access to food at any time;
- Allow visitors of choosing at any time;
- Are physically accessible;
- Requires any modification (of the additional conditions), under 42 CFR 441.301(c)(4)(VI)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.

It is not the intention of North Carolina to eliminate any day or residential options, or to remove access to services and supports. The overall intent of the State's plan is to ensure that individuals receive Medicaid HCBS in settings that are fully integrated and support access to the greater community.

North Carolina DHHS Statement of Progress and Plan of Action

Engagement, Outreach, and Public Notice/Comment (October 1, 2014 – March 17, 2018):

HCBS Stakeholder Advisory Committee: Conversations about the HCBS Final Rule began in the spring of 2014 and generated valued stakeholder input. At the heart of the engagement effort is the HCBS Stakeholder Advisory Committee, convened by DHHS. This group worked closely together to develop and implement a shared approach for crafting North Carolina's Statewide Transition Plan. In addition, DHHS established a full complement of personnel to work in collaboration with the Stakeholder Committee to ensure North Carolina's primary full compliance with the HCBS Final Rule (March 17, 2014). The Department supported its staff by hosting technical assistance opportunities with the National Association of State Directors of Developmental Disabilities (NASDDDS), a subject matter expert on best practices that align with HCBS setting requirements. This collaboration ensured there was adequate preparation of State staff to support the HCBS Stakeholder Advisory Committee.

The HCBS Stakeholder Advisory Committee's composition is as follows:

ADVOCATES and STAKEHOLDERS

Anna Cunningham, State Consumer and Family Advisory Committee
Jean Anderson, Stakeholder Engagement Group for Medicaid Reform/Advocate
Kelly Beauchamp, Advocate
Kelly Mellage, Advocate
Sam Miller, NC Council on Developmental Disabilities/Family Member
Yukiko Puram, Advocate
Sue Guy, State Consumer Family Advisory Committee (SCFAC)
Kerri Erb, Developmental Disabilities Consortium
Patricia Amend, North Carolina Housing Finance Agency
Richard Rutherford, SembraCare (Home Care Software Company)
Jennifer Bills, Disability Rights of North Carolina

PROVIDER ORGANIZATIONS and AGENCIES

Peggy Terhune, Ph.D., Monarch, Inc. (Provider)
Bridget Hassan, Easterseals UCP (Provider)
Melissa Baran, Enrichment Arc (Provider)
Jenny Carrington, ABC Human Services (Provider)
Bob Hedrick, North Carolina Providers Council
Tara Fields, Benchmarks, Inc.
Teresa Johnson, North Carolina Adult Day Services Association
Curtis Bass, North Carolina Providers Association
Peyton Maynard, North Carolina Developmental Disabilities Facilities Association
John Nash, The Arc of North Carolina

LME-MCOs (PIHPs)

Rose Burnette, East Carolina Behavioral Health
Andrea Misenheimer, Cardinal Innovations Healthcare Solutions
Christina Carter, Smoky Mountain LME-MCO
Foster Norman, CoastalCare

Local Lead Agencies (Case Management Entities)

John Gibbons, RHA Howell
Jane Brinson, Home Care of Wilson Medical Center
Rita Holder, Resources for Seniors

STATE GOVERNMENT

Division of Medical Assistance
Division of Mental Health/Developmental Disabilities/Substance Abuse Services
Division of Health Service Regulation
NC Council on Developmental Disabilities

Outreach: To ensure consistent, clear, streamlined communication with waiver beneficiaries, families, provider organizations and associations, as well as other interested stakeholders, DHHS established a dedicated web portal and posted information on its website. Data for the time period, denoted below, provided the following information:

Source	Date	% of Total
Home Page	Jan 26 2015 – Oct 5 2015	35
Self-Assessment Page	Jan 26 2015 – Oct 5 2015	27
Provider Self-Assessment	Jan 26 2015 – Oct 5 2015	16
Public Notice & Comments	Jan 26 2015 – Oct 5 2015	12
Listening Sessions	Jan 26 2015 – Oct 5 2015	3
Plan Submission	Jan 26 2015 – Oct 5 2015	2
Vision	Jan 26 2015 – Oct 5 2015	1

Total of 29562 Pageviews

This source provides information and links focused solely on the implementation of the HCBS Final Rule (March 17, 2014) including the rule, the self-assessment and review process, deadlines for compliance, and availability of technical assistance.

In addition, DHHS conducted a live webinar to include the information that was shared during the Listening Tour, and posted a recorded webinar to allow for on-going access to information throughout the full implementation of the plan. The webinar afforded opportunity for both audio and video access. A “chat feature” allowed for “real time feedback” during the webinar. Frequently asked questions are also posted at <http://www.ncdhhs.gov/hcbs/index.html>. The website was updated to include the public

comment from the 30 day posting period as well as the initial submission of the plan to CMS. It will continue to be updated as the plan is updated and self-assessment data is available.

Other communication has included:

- Stakeholder Chat Sessions, or face- to- face conversations;
- A plain language (“people first”) version of the transition plan;
- Email communication “blasts”;
- Materials through U.S. mail;
- Meetings with LME-MCO and Local Lead Agency Partners;
- Meetings with Providers;
- Meetings with members of the advocacy community;
- DHHS press release with a distribution list of approximately 80,000 recipients;
- Frequently Asked Questions Document (FAQs);
- Power Point presentations;
- Blog Post;
- Twitter Postings
- A weekly Q&A throughout the self-assessment process

DHHS’s informational materials have cascaded to diverse audiences through stellar efforts of the LME-MCOs/Local Lead Agencies, provider and advocacy organizations. This partnership has served to educate a broad group of beneficiaries and their families, addressing questions and conveying the importance of stakeholder feedback. Such efforts will continue to be central to DHHS’s work throughout the plan implementation.

Additional efforts were made to inform and engage Medicaid beneficiaries and their families. DHHS conducted strong outreach efforts with the State and Local Consumer and Family Advisory Councils (CFACs) as well as the individual stakeholder groups within each of the LME-MCOs/Local Lead Agencies. DHHS Leadership responded to individual and family member inquiries via email, personal telephone conversations, and face-to-face meetings. The NC Stakeholder Engagement Group for Medicaid Reform (SEG) - a cross disability group, funded by the NC Council on Developmental Disabilities (whose primary focus is to help individuals most impacted by the system to have a meaningful voice in public policy) assisted by engaging in conversations as very well informed individuals and families. The SEG also organized a series of Consumer and Family Community Chats on the HCBS rule, in response to feedback from the public forum held on January 16th, 2015. Beneficiaries, at that forum, requested an opportunity to have their voices heard without the presence of providers or LME-MCOs/Local Lead Agency representatives. The State listened as DHHS Leadership met face-to-face with attendees where heartfelt “stories” were shared about the system, services and what needs to occur as North Carolina implements the transition plan. The SEG hosted all five of the sessions across the State.

Education efforts with the LME-MCOs/Local Lead Agencies were also extensive. DHHS held a series of conference calls in February, 2015 for members of these agencies and offered face-to-face opportunities to share information and obtain feedback regarding the rule, the process for achieving compliance, and DHHS’s vision as it pertains to the implementation of and on-going compliance with the Final Rule. The State has also offered to engage with each of the stakeholder groups of the nine LME-MCOs as well as the Local Lead Agencies. The on-going dynamic of these partnerships will continue to evolve throughout the pilot assessment, self-assessment, monitoring, and on-going compliance phases of plan implementation.

DHHS developed the draft plan and the proposed Provider Self-Assessment in conjunction with the HCBS Stakeholder Committee between October, 2014 and January, 2015. Revisions to both documents followed based on feedback received via multiple venues, e.g., public comment, Listening and Chat Sessions, a public forum with the Stakeholder Engagement Group for Medicaid Reform, State and Local CFACs meetings; meetings with provider organizations and LME-MCOs/Local Lead Agencies. Across the State, DHHS leadership met face-to-face with attendees at various sessions. Participants shared personal experiences with services, helping DHHS to pinpoint needs as North Carolina implements the transition plan.

Public Comment: DHHS posted the transition plan and proposed self-assessment at <http://www.ncdhhs.gov/hcbs/index.html> for a 30 day Public Comment on January 21, 2015. Notice of the public comment period was announced through the dedicated Department (DHHS) website, LME-MCO/Local Lead Agency outreach, and communications via provider organizations and the broader stakeholder community. The public comment period provided interactive opportunities for dialogue with all vested partners.

DHHS placed additional emphasis on ensuring that access to the information was available through a variety of mediums: web-based, hard copy via U.S. Mail, email listservs; individual responses to personal emails with attachments as warranted, translation to other languages as requested, e.g. Spanish, and public verbal presentations inclusive of interpreters for participants who were deaf or hard of hearing.

Releasing the plan for comment ensured that all stakeholders were fully informed of DHHS’s plan for meeting the HCBS Final Rule (effective March 17, 2014). At the conclusion of the Listening and Chat Sessions, information was captured in an “At a Glance” format and shared with the broader stakeholder community and posted to the dedicated website. Public comments are maintained by the Department and will be posted to the website.

Listening Sessions: During the public comment period, DHHS hosted eleven (11) listening sessions. In these meetings, the Department shared information regarding the Rule (HCBS Final Rule March 17, 2014), the proposed transition plan and self-assessment tools. Feedback was obtained from a broader stakeholder base. These sessions were held in the locations, noted below, from February 2 through February 12, 2015. The Sessions, by design, were for the primary purpose of “listening” to beneficiaries and their families. To aid in the facilitation of the meetings, a PowerPoint presentation was utilized along with wall charts depicting input as it was received. In addition consumer/family friendly materials were available to assist with gleaned as much feedback as possible. All of these efforts, in turn, have helped the State finalize a plan that clearly meets intent according to the voices of its very recipients. Special consideration was given to determining the specific locales, for each of the sessions, to ensure the best possible access and participation from individuals supported through the HCBS waiver.

It has been the position of the Department that any change in policy should occur following the Listening and Chat Sessions, as the voice of our beneficiaries is paramount in not only establishing policy as it relates to the implementation of this Plan, but improving real life outcomes and system wide accountability. As voiced throughout statewide reform efforts, and now has resonated again throughout the Listening Sessions, “nothing about me, without me”.

Location of Public Sessions	Number in Attendance
Lincolnton, North Carolina	54

Raleigh, North Carolina	73
Greenville, North Carolina	43
Winston-Salem, North Carolina	62
Wilmington, North Carolina	42
Asheville, North Carolina	42

Location of Consumer and Family Sessions	Number in Attendance
Raleigh, North Carolina	9
Greenville, North Carolina	8
Winston-Salem, North Carolina	21
Wilmington, North Carolina	6
Asheville, North Carolina	18

Common themes from public comment and listening sessions included the following:

Concern/Suggestion	Frequency
1) Heightened Scrutiny of Day Services, but not elimination. The impact would be devastating and have unintentional negative consequences for many.	All Sessions
2) Education for Potential Employers relative to positive benefits, liability, and to reduce anxiety – also development of employer incentives – linkage of employers that do employ to those that do not; integrated employment.	All Sessions
3) Transportation	All Sessions
4) Service Definitions	All Public Sessions
5) Reimbursement Structure	All Public Sessions
6) System of Outcomes	All Public Sessions
7) Education/Focus on Natural Supports	All Sessions

Public Comment Analysis: THE HCBS Worksheet Analysis, inserted below, provides a synopsis of the narrative feedback received during the comment period.

HCBS Feedback Worksheet - Narrative Analysis

	Source Breakdown					
	Email	Phone	Correspondence	Fax	Session Attendees	Total of All
Grand Totals	308	0	0	6	323	637
Stakeholders	76	0	0	0	304	380
Per Cent of Source Group	24.7%	0.0%	0.0%	0.0%	94.1%	59.7%
Advocacy Groups	99	0	0	0	0	99
Per Cent of Source Group	32.1%	0.0%	0.0%	0.0%	0.0%	15.5%
Providers/Provider Organizations	40	0	0	6	19	65
Per Cent of Source Group	13.0%	0.0%	0.0%	100.0%	5.9%	10.2%
LME-MCOs/LLA	4	0	0	0	0	4
Per Cent of Source Group	1.3%	0.0%	0.0%	0.0%	0.0%	0.6%
Stakeholder Committee	89	0	0	0	0	89
Per Cent of Source Group	28.9%	0.0%	0.0%	0.0%	0.0%	14.0%
State Gov	0	0	0	0	0	0
Per Cent of Source Group	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

	Accept/Consider Breakdown		
	Accept - A	Consider - C	Total of All
Grand Totals	365	272	637
Stakeholders	235	145	380
Per Cent of Source Group	64.4%	53.3%	59.7%
Advocacy Groups	59	40	99
Per Cent of Source Group	16.2%	14.7%	15.5%
Providers/Provider Organizations	25	40	65
Per Cent of Source Group	6.8%	14.7%	10.2%
LME-MCOs/LLA	4	0	4
Per Cent of Source Group	1.1%	0.0%	0.6%
Stakeholder Committee	42	47	89
Per Cent of Source Group	11.5%	17.3%	14.0%
State Gov	0	0	0
Per Cent of Source Group	0.0%	0.0%	0.0%

Note: Each point of feedback is individually counted specific to affiliation, e.g. 1 person could have 20 points and each is counted as a separate entity.

Additional data is also contained within this worksheet and is available for reference. Public comments, received through email, hand written correspondence, fax, testimony and input from the eleven (11) listening sessions, were analyzed and incorporated, as deemed necessary by DHHS staff. The plan was finalized in early March 2015.

The Department seeks to ensure wide internet-based access, therefore, dedicated web pages with the same information were posted to the Division of Medical Assistance (<http://www.ncdhhs.gov/dma/lme/Innovations.html>) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Service (<http://www.ncdhhs.gov/mhddsas/providers/IDD/index.htm>) websites.

Plan Posting: The final plan, as submitted, is posted to the North Carolina DHHS website <http://www.ncdhhs.gov/hcbs/index.html>. Please note that this updated transition plan is being submitted at the request of CMS based on their call with the State on 9/25/15. Additional public comment has not been sought on this update. This document will be placed on our HCBS website and additional public comment will be garnered prior to the submission of the final transition plan.

Moving Forward: DHHS, in conjunction with the LME-MCOs/Local Lead Agencies (Case Management Entities), will continue to solicit feedback to enhance implementation activities, to identify barriers to compliance, and to highlight areas of success in preparation for submission of future waiver amendments and/or comprehensive plans. This will occur through multiple frameworks. Feedback will have “no wrong door”, a point emphasized to stakeholders throughout the plan development phase. DHHS will furthermore ensure that anyone desiring to provide additional feedback will continue to have the same degree of access, through all established venues, as was available during the Public Comment time period. The HCBS Stakeholder Advisory Committee will continue in their role while the partnership with the NC

Stakeholder Engagement Group will funnel into DHHS's work - on-going broad-based input from the greater community of individuals receiving waiver supports.

The Transition Plan and subsequent updates and materials will remain posted online for the duration of the transition time period.

Assessment and Remediation

State Self-Assessment and Remediation (November 25, 2014 - March 16, 2018):

The HCBS Final Rule for Home and Community Based Services applies to three 1915(c) waivers and select services offered under the 1915 (b)(3) benefit operated by the State of North Carolina. Services under the North Carolina waivers are provided in a variety of settings.

- Under the CAP C waiver, individuals may receive services at home where they reside with their family or in foster homes. CAP C considers foster homes in the same way as natural homes. Services are provided on a periodic basis by outside providers. CAP C does not reimburse the foster family for providing a service. Institutional Respite may also be provided in a Skilled Nursing Facility (SNF).
- Under the CAP DA/Choice waiver, individuals may receive services at home where they reside with their family or in Adult Day Health facilities (certified under 131-D). Institutional Respite may also be provided in a SNF.
- Under the Innovations waiver, individuals may receive services in their home or in the home of their family, in licensed (5600(b) and (c) group homes and licensed Alternative Family Living arrangements (5600(f))/unlicensed residential settings (serving one adult), in the community, in certified Adult Day Health/Adult Day Care(131 D) facilities, Day Support facilities (2300 facilities). Institutional Respite may be provided in an ICF-IID facility.

North Carolina has assessed the waiver service settings and determined that the services that the rule will impact are:

- NC Innovations: Residential Supports (provided in 5600 b and c group homes, licensed 5600(f) AFLs, and unlicensed AFLs), Day Supports (provided in 2300 licensed day programs as well as adult day health/care programs certified under 131D), and Supported Employment
- CAP/DA and CAP/Choice waivers: Adult Day Health (certified under 131D)
- 1915(b)(3) services: Supported Employment (IDD/MH/SAS) and the De-institutionalization service array services of Day Supports, Supported Employment and Residential Supports.

North Carolina determined that no services under the CAP/C waiver would be affected by the rule as the services are based in the home.

While the statewide assessment data is not yet fully analyzed, as of 9/11/15 the following numbers of sites/beneficiaries had been identified in the provider self-assessment process:

Services	Sites	Beneficiaries
Day Supports	661	5,669
Residential Supports	2045	4,388
Supported Employment	690	1,354
Adult Day Health	44	271

As of 9/11/15, there were 661 sites for Day Supports, 2045 sites for Residential Supports, 690 sites for Supported Employment and 44 sites for Adult Day Health. We anticipate that an estimated 3,368 of 3437 sites will be able to be compliant with remedial action/technical assistance. This number is based on 2% of our provider sites potentially not meeting compliance. The State surveyed the PIHPs (as well as the Adult Day Health facilities providing services under CAP DA) on their anticipated numbers of sites that would be either clearly not compliant or not able to become compliant and facilities for which the State may submit evidence under heightened scrutiny. Based on the information reported, we anticipate that one site that may not be complaint and we anticipate that we will submit nine requests for heightened scrutiny.

The State has surveyed the PIHPs on the number of (b)(3) service sites that are enrolled in their networks and will include this information as well as self-assessment data with the final transition plan.

DHHS continues to review the current LME-MCO/Local Lead Agency contract/agreement to determine changes/modifications warranted for ensuring transition plan compliance. System alignment with the Rule (to ensure that processes, regulations, and policy fully support the Rule is the desired outcome for the State of North Carolina.

Rules:

The State is strategically vetting the current State system processes and regulations that could impact or be impacted by the implementation of the transition plan. This includes a comprehensive, in-depth crosswalk of State statutes, existing administrative code, rules, waiver service definitions, provider qualifications and licensing, as well as rate structures. The review will identify areas where changes will be needed to ensure initial and on-going compliance with the Rule. This systemic crosswalk is crucial to the process of identifying specific areas that could impede implementation. A preliminary review was completed at the time of plan submission, with initial input, to date, received from the Division of Health Service Regulation, Division of Medical Assistance, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Waiver Policy:

Although an integral component of the current waivers, DHHS continues to assess its person centered planning and thinking processes concurrent with the HCBS Rule Process. In addition, specific timelines and benchmarks for achieving and ensuring full compliance with the Final Rule will occur as a fluid component of this process. The State, through the Division of Medical Assistance (DMA) will update existing waivers and policies (Clinical Coverage Policies 8-P – NC Innovations, 3K-1 Community Alternatives Program for Children, 3K-2 community Alternatives Program for Disabled Adults and Choice Option) to include the HCBS standards specific to the characteristics, monitoring and on-going education. The CMS Doc 7 NCDHHS Transition Plan Update October 2015

process for ensuring these standards are maintained will also be incorporated into waiver policy. The policy will be promulgated through the regular DMA policy process. The changes will be added to subsequent waiver amendments and submitted to CMS for review and approval.

The State, through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), will review, revise and adopt policy relative to its vision, outcome measures, and core indicators to ensure full compliance with the rule. Any change in current policy will occur through established Departmental processes.

LME-MCO/Local Lead Agency (Case Management Entity) Self-Assessment and Remediation (February 1, 2015 – December 31, 2015):

Concurrent to the comprehensive State review, LME-MCOs/Local Lead Agencies will also conduct self-assessments. The LME-MCO/Local Lead Agency will review all policies, procedures and practices, training requirements, contracts, billing practices, person-centered planning requirements and documentation, and information systems to determine their compliance with the Community Rule. The State will provide a framework for the completion of the review to maintain consistency across all agencies. DHHS will require each LME-MCO/Local Lead Agency to submit its assessment along with evidence of compliance to the State. Each LME-MCO/Local Lead Agency will identify any modifications needed to achieve compliance with the rule. The State's review of each LME-MCO's/Local Lead Agency's assessment and evidence of compliance will ensure that all aspects of the system are aligned with CMS expectation and the State's framing of the rule. Any changes needed to achieve compliance will be incorporated in an amendment to the Transition Plan, including a specific timeline and identified milestones.

All revisions to systems/operations and materials needed to achieve compliance will be submitted to the State for review and approval. The State will conduct on-site reviews of the LME-MCOs/Local Lead Agencies as indicated by need following review of the assessment.

Please note that the State's contract with the PIHPs ensures that there is no fiduciary link between the local agencies and the providers that are being assessed:

1.7 Conflict of Interest:

As required by 42 C.F.R. § 438.58, no officer, employee or agent of any State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall acquire any personal interest, direct or indirect, in this Contract or in any subcontract entered into by PIHP. No official or employee of PIHP shall acquire any personal interest, direct or indirect, in any Network Provider, which conflict or appear to conflict with the employee's ability to act and make independent decisions in the best interest of PIHP and its responsibilities under 42 CFR Part 438 and other regulations applicable to Medicaid managed care organizations.

PIHP hereby certifies that:

- a. no officer, employee or agent of PIHP;
- b. no subcontractor or supplier of PIHP; and
- c. no member of the PIHP Board of Directors;

is employed by the State of North Carolina, the federal government, or the fiscal intermediary in any position that exercises any authority or control over PIHP, this Contract, or its performance. Pursuant to CMS State Medicaid Director Letter dated 12/30/97 and Section 1932(d)(3) of the Social Security Act, PIHP shall not contract with the state unless PIHP has safeguards in place that are at least equal to Federal safeguards provided under section 27 of the Office of Federal

Procurement Policy Act (41 U.S.C. 423).

For Adult Day Health facilities, DMA will be reviewing all self-assessments to assure compliance to the final rule.

The State has strategically worked with the stakeholder community inclusive of Individual's receiving supports, PIHPs, Providers, Advocacy Groups, Provider Organizations, etc. to ensure that there is no personal conflict of interest between private interests and official responsibilities as streamlined processes were developed for an unbiased implementation, completion and review of the comprehensive self-assessment process.

Provider Self-Assessment and Remediation (March 17, 2015 - March 16, 2018):

The State collaborated with stakeholders to develop a provider self-assessment tool and a comprehensive companion guide for providers to evaluate compliance with HCBS Final Rule. The assessment includes identification of the type of setting and service provided, evidence supporting compliance with HCBS standards, and proposed remediation for standards that are out of compliance.

The State conducted a pilot of the self-assessment to establish that the tool captured all of the required waiver elements and was universally understood. The initial plan for the self-assessment involved all of the LME-MCOs and a random sample of Local Lead Agencies. It included a defined number of providers (not to exceed 108) representative of large, medium and small providers from each of the Networks/Entities. Providers were not duplicated in the sample. The assessment was completed using an electronic, online tool. The preliminary self-assessment proposal was reviewed by the LME-MCO/Local Lead Agencies prior to submission of the plan. A final work plan was completed and presented to the HCBS Stakeholder Advisory Committee. The pilot self-assessment submission occurred May 11, 2015 through May 24, 2014. There were 224 submission from Innovations waiver providers and 13 submission from CAP DA/Choice.

From the pilot, the state determined that:

- An save feature needed to be developed
- Evidence should reflect current systems and practices, not just a cut and paste of rules/regulations
- Information provided in a plan of action must include specific detail regarding how the site will meet the characteristic.

The State will be receiving provider self-assessments for 100% of Residential Supports, Day Supports, and Adult Day Health sites. Supported Employment self-assessments will be completed on 100% of corporate sites and 10% or 10 individual job sites per provider, whichever is larger. After the initial self-assessment process, individual job sites will not be required to undergo self-assessment as discussed with CMS on 9/25/15. Providers will submit self-assessments, along with the evidence of compliance, to the assigned LME-MCO/DMA) on or before September 15th, 2015. The State requested an extension to the six months within which assessments should be completed as we had published the timeframe of 7/15/15 through 9/15/15 for the statewide provider self-assessment process. CMS granted this three day extension on 8/25/15. The State, in concert with the LME-MCOs/Local Lead Agencies will 1) determine if individual provider assessments are compliant with the rule, 2) identify providers that need

technical assistance to ensure compliance, and 3) identify providers out of compliance and assess their intent and capacity with technical assistance to comply. This will be accomplished using a standardized process with a standardized e-Review tool and companion document for evaluation of the provider's compliance. Additional evidence may be requested or subsequent reviews conducted, as needed, to further assess and validate compliance. The statewide assessment is projected to be complete by September 15th, 2015. Providers that self-report or are determined to be out of compliance by the responsible LME-MCO/Local Lead Agency will be required to submit a plan of action to achieve conformity with the rule, inclusive of time lines. The State has established expectations that remediation will occur on an ongoing basis with progress reviewed at the following intervals: Six months, one year, two years, and three years with the goal of full compliance for all providers by March 2018. Self-assessments are to be submitted with plans of action to show remediation the provider will implement to ensure full compliance with the rule. Assessments/plans of action will be reviewed at the aforementioned intervals to determine if full compliance has been achieved. Remediation starts as of the date of the acceptance of the self-assessment by the PIHP or DMA. Acceptance indicates that the information as presented has been reviewed and the plan to meet the final rule is sufficient. Technical assistance will be provided throughout the process. The e Review tool affords an operational function that will facilitate the tracking/monitoring of the plans of action and correspondence between the provider and the PIHP or DMA. Reviewing entities will adhere to the thresholds established in the plan and will be submitting ongoing analysis to the State. All reviews can be accessed by the State throughout any phase of this process, thus making it seamless, streamlined and manageable in real time by all parties.

Heightened Scrutiny:

Any setting that is presumed to have the characteristics of an institutional environment, will be subject to heightened scrutiny. The State has incorporated into the e Review process a function that immediately denotes if a setting/site has the qualities of an institution. Once identification occurs, the State has engaged a process through the development of threshold assessment to determine if heightened scrutiny is warranted. The PIHP/DMA will immediately share the form with the provider agency if it appears that heightened scrutiny may apply. The provider will have 10 working days to complete and return the threshold assessment. Follow up will occur as indicated based on the review of the form within 5 working days. If the site is not found to warrant heightened scrutiny, the assessment process will continue as with any other provider. If the site is found to warrant heightened scrutiny, then a site visit by the PIHP and/or DMA will be conducted within 14 days of the determination to determine if there is sufficient evidence to demonstrate that the setting is not institutional in nature; whether technical assistance can support the achievement of compliance; or whether a compliant setting will have to be identified for the provision of the service(s). If a setting is found to meet heightened scrutiny per the rule, but demonstrates that it can meet the HCBS rule, then the State will request public comment on each setting in question; and submit the site for approval by CMS.

Providers requiring technical guidance on how to achieve compliance may request assistance from the State, LME-MCO/Local Lead Agency or another provider (of the same service type to ensure service continuity) that is in full compliance with the rule. Assistance secured from an entity other than the State will not negate the provider's inclusion in State monitoring protocols.

For providers that, following review, are deemed unable or unwilling to comply with the HCBS Final Rule DHHS will mandate a plan of remediation, with a 30 day deadline from date of issuance to conform fully. If compliance does not occur within 30 days, the provider will be prohibited from providing the service in question at that site until such time there is full compliance with the rule. The provider may be removed from the LME-MCO Network or the agreement with the Local Lead Agency may be terminated if deemed appropriate by the contractor.

In the event of this circumstance, the provider will be obligated to:

1) Create and implement a plan, detailing how individuals who utilize the provider's services at a location that is out of compliance will be transitioned to a more integrated (compliant) setting within their service capacity, only if the individual elects to continue receiving the services within the purview of the rule.

2) Facilitate the seamless transition of individuals supported to an appropriate provider of "like" service so there is no service interruption.

Person-Centered Planning meetings will be held as determined by the individual and his/her team. Transition should be complete by March 2018. DHHS will monitor monthly, the transition of individuals until the transition is complete. The State, in conjunction with the LME-MCOs/Local Lead Agencies will oversee all necessary transition processes. A minimum of 60 days' notice will be provided to all individuals required to transition to another provider (unless there is imminent need to expedite the transition process). More notice may be granted in instances where other housing options are being secured (specific to the service of residential supports only). To ensure continuity of care and as little disruption to an individual's life as realistically possible, each person will receive a detailed description/notice of the process in plain language and a comprehensive listing of providers to consider for continuation of services from the LME-MCO/DMA. Assigned LME-MCO or Local Lead Agency/DMA Staff in conjunction with DHHS staff will schedule a face-to-face visit with the beneficiary and his/her guardian(s) (with subsequent visits occurring based on the specific needs of the individual) as soon as possible, but no later than 14 days after becoming aware that a new service option needs to be pursued to discuss the transition process and ensure the individual and family has been fully informed of any applicable due process rights. The State, in partnership with the LME-MCO/Local Lead Agency, will ensure there is transitional support for the beneficiary, and their family during the transition process.

The LME-MCOs/DMA will complete a detailed review of the settings determined to be "at risk" with the State conducting final review and disposition. In conjunction with the State, they will also establish the process to make sure that there is continuity of care. Individuals who are in settings that cannot meet the rule's requirements will not experience any interruption in services. Similarly, in partnership with the State, LME-MCOs/Local Lead Agencies will determine which providers who could meet the standards, were they provided with technical assistance. Each LME-MCO/Local Lead Agency will submit its analysis to DHHS. The State's response, following review, may include, but is not limited to, direction that the setting requires further remediation; requests for additional documentation; or confirmation of an assessment that the setting complies with the rule.

The State, in conjunction with the LME-MCOs/DMA, will establish a Monitoring Review Process to validate a representative sample of provider self-assessments after the LME/DMA review of the assessments is completed. This review will confirm overall integrity of the self-assessment process. LME-MCO Designated Departments, Local Lead Agency) designees and DHHS/DMA/DMHDDSAS staff will

validate a State determined percentage of provider self-assessments (initial assessment data in comparison to validation data). In order to meet the State's intent to oversee, support, offer technical assistance and ensure full compliance with the setting requirements of the HCBS rule, North Carolina will identify subject matter experts specific to the rule and plan; comprise (possibly interface with an existing team) a diverse team to develop and oversee this process, engage in methods that promote consistent interpretation of the requirements; facilitate education and training of appropriate parties; and engage, as part of the process, a component that provides inter- and intra- rater reliability among all reviewing agents (State team members as well as LME-MCO/Local Lead Agency Team Members). The Monitoring Oversight will delineate timelines for this review, but no less often than annually. During the plan's implementation period, however, the schedule of review will be more intense, with plans to conduct three times in year one, two times in year two, and one time in year three. For on-going compliance the proposal is to include the monitoring as part of a comprehensive annualized review. As there is systemic review of the State's monitoring practices presently underway, every effort will be directed toward streamlining this process to ensure efficient and effective practices with the overall objective being compliance with the HCBS Final Rule.

My Individual Experience Assessment:

Based on stakeholder feedback, the State is committed to the utilization of an assessment completed by the individual receiving waiver services. This assessment will be mirrored against the provider assessment, however will be provided in formats that are easily understood, in person first language, and will contain graphics. The assessment asks for the provider/site where individuals receive services so that the information received can inform the assessment of the provider/site. In addition to soliciting the input from the Stakeholder's group in the development of the My Individual Experience assessment, DMH/DD/SAS and DMA have also enlisted the assistance of the State's ADA Statewide Coordinator, who has a background in developing materials for people with I/DD as well working with grassroots advocacy groups promoting the inclusion of people with disabilities. People with IDD and their families will be engaged in vetting the document and incorporate any desired modifications. The State feels that this is a critical part of the process in order to yield valuable insights to the services provided. A representative sample of individuals will be chosen to participate each year based on the number of individuals served in each service per MCO. The data gathered from the finalized assessment will provide DHHS/DMA with actionable insight on the individual's desires. A survey that does not support that the individual has integration in the community to the extent the individual desires will illicit follow-up from the Care Coordinator/ Case Manager. An analysis of surveys and actions taken will be submitted to DHHS annually.

Initial Compliance and Update to Transition Plan:

Throughout the initial compliance process strategic action plans will be developed (as warranted) in concert with the Transitional Grid items so that all identified areas are addressed. The initial plan will be specific to the Self-Assessment pilot. No later than March 1, 2016, upon completion of provider network self-assessment surveys and in conjunction with the validation of the sample of assessments, the State will submit an amendment to this transition plan with specific remediation activities and milestones for achieving compliance with the HCBS Rule. Upon approval of the amendment by CMS, the State will submit Technical Amendments to its waivers to include the full transition Plan. For providers needing compliance assistance, the State proposes the following strategies from July 1, 2015 through June 30, 2018:

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- Facilitate focus groups for providers that are both in and out of compliance with the Rule to encourage peer to peer support, problem solving process.
- Provide technical assistance through the development and scheduling of on-going training regarding the Community Rule compliance, changes to the broader waiver and the overall effect on services.
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Ongoing Monitoring/Compliance:

Analysis of the self-assessment data from the PIHPs and DMA is due by January 16, 2016. During the transition period providers that are not in full compliance with the HCBS Final rule will receive ongoing TA as needed with progress reviewed at the following intervals: six months, one year, two year, and three year with the goal of full compliance for all providers by March 2018.

Additional tools are being developed with the goal of incorporation into the Statewide Monitoring Process that is utilized for all PIHP providers (Medicaid and State services) which occurs every two years. A separate workbook will be included in the tool to ensure that the tool can be utilized either as an integral part of the existing tool or as a stand-alone tool contingent on the specific need. The Statewide Monitoring Workgroup will work in partnership with the HCBS Strategic Workgroup to develop and vet the specific tool. All elements of this tool will be unique to the HCBS Final Rule. From preliminary meetings, the representative sample for on-going monitoring will be 10% annually. For ongoing monitoring for CAP DA/Choice this will be streamlined into the regular monitoring completed by the Local Lead Agency Case Manager. Information received from the completion of the “My Individual Experience Assessment” will be used to monitor individual experience at the HCBS site.

Care Coordinator/Case Management monitoring will continue, ensuring that participants are receiving services consistent with their person-centered plan and CMS requirements. These processes will deliver a continuous monitoring and oversight system to assure that providers are offering services and supports that are consistent with HCBS.

Once overall compliance has been achieved, ongoing compliance will be ensured through:

- Regular solicitation of feedback from individuals supported through the waiver, providers, provider organizations, and LME-MCOs/Local Lead Agencies;
- Annual consumer satisfaction surveys;
- Regular review of contracts with LME-MCOs/Local Lead Agencies (Case Management Entities) to ensure on-going compliance with standards;
- Identification or development of specific quality assurance/improvement measures that ensure compliance with the rule ;
- If necessary and feasible, implement an Individual (My) Life Experience Assessment through the Person Centered Planning Process;
- Continuation of a collaborative monitoring oversight process between the LME-MCOs/Local Lead Agencies and the State;
- Consideration, in conjunction with LME-MCOs/Local Lead Agencies and the broader Stakeholder community, of the creation of a public service campaign to promote the integration of individuals served under the HCBS waivers within their communities;

- Continued technical assistance and education to individuals and their families, LME-MCOs/Local Lead Agencies, Provider Community and broader stakeholder community will be provided;
- State will explore the use of National Core Indicators and other comparable data to support ongoing compliance and monitoring efforts; and
- Continued partnership with the HCBS Stakeholder Committee and the NC Council on Developmental Disabilities Stakeholder Engagement Group for Medicaid Reform (SEG).

Conclusion:

North Carolinians who receive Medicaid waiver services and supports must have access to the same benefits of living in a community as others do. The State of North Carolina seeks an improved future in which services promote full integration into community life and enhance each person's opportunity to achieve the outcomes that matter to all of us. We affirm our dedication to working in partnership with people who use, or seek to use, home and community based waiver services, their families, allies and other valued stakeholders, to affect change.