North Carolina Home and Community Based Services Final Rule Transition Plan

(42 CFR Section 441.301 (c) (4) (5) and Section 441.710(a) (1) (2))

Department of Health and Human Services

Division of Health Benefits

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

June 15, 2022

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Executive Summary

The Home and Community Based Services (HCBS) final rule directed the Department of Health and Human Services (DHHS) to ensure individuals receiving services through its 1915(c) waivers have full access to the benefit of community living and the opportunity to receive services in the most integrated setting possible. DHHS engaged stakeholders to draft a successful, transition plan which complies with the HCBS final rule. This transition plan addresses assessment, remediation, stakeholder engagement, education, and milestones for achieving full compliance with this rule.

Purpose

North Carolina's transition plan for all waiver beneficiaries provides individuals with 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 system performance will reflect this commitment. The Department's plan will clearly describe the actions that will be taken to ensure, by 2023, initial and ongoing compliance with all aspects of the HCBS Final Rule. The DHHS will partner with and support the Prepaid Inpatient Health Plans (PIHPs), known as Local Management Entities-Managed Care Organizations (LME/MCOs) in North Carolina, and Local Lead Agencies[1](LLAs) in meeting the HCBS Final Rule's intent; however, DHHS is ultimately responsible for the review, modification and monitoring of any laws, rules, regulations, standards, policies agreements, contracts and licensing requirements necessary to ensure that North Carolina's HCBS settings comply with HCBS Final Rule requirements.

The federal citations for the main requirements of the HCBS Final Rule are 42 C.F.R. 441.301(c)(4)(5), and Section 441.710(a)(1)(2). More information on the HCBS Final Rule can be found on the CMS website at www.Medicaid.gov.

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

Home and Community Based Services Final Rule Setting Requirements:

Home and Community Based Settings Requirement

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS;
- 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;
- Facilitate individual choice regarding services and supports, and who provides these services.

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;
    - Units have lockable entrance door lockable by the individual, with appropriate staff having keys to doors as needed.
    - Individuals sharing units have a choice of roommates in that setting.
    - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- 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 DHHS to eliminate any day or residential options, or to remove access to services and supports. The overall intent of North Carolina's Statewide Transition Plan (STP) is to ensure that individuals receive Medicaid HCBS in settings that are fully integrated and support access to the greater community.

Home and Community Based Services in North Carolina

North Carolina conducted an internal review of its state statutes and regulations governing Medicaid HCBS waiver services and assessed that the HCBS Final Rule applies to three 1915(c) waivers and select services offered under the 1915(b)(3) benefit operated by North Carolina. Services under the North Carolina waivers are provided in a variety of settings.

- Under the Community Alternatives Program for Children (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 an HCBS service. Institutional Respite may also be provided in a Skilled Nursing Facility (SNF).
- Under the Community Alternatives Program for Disabled Adults (CAP/DA) 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 facilities licensed under 10A NCAC 27G.5601(c)(2) and (3) (referred to as 5600(b) and (c) group homes) and licensed under 10A NCAC 27G.5601(c)(6) (referred to as Alternative Family Living arrangements (or licensed AFLs) (5600(f))/unlicensed residential settings serving one adult (referred to as unlicensed AFLs), in the community, in Adult Day Health/Adult Day Care facilities certified under NC GS 131 D), and Day Support facilities licensed under 10A NCAC 27G.2301(referred to as 2300 facilities) and 10A NCAC 27G.5400. Institutional Respite may be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) facility.

North Carolina assessed the waiver service settings and determined that the services that the

HCBS Final Rule will impact are:

- NC Innovations Waiver: services include 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 and adult day health/care programs certified under 131D), and Supported Employment
- CAP/DA and CAP/Choice waivers: services include Adult Day Health (certified under 131D)
- 1915(b)(3) services include Supported Employment (IDD/MH/SAS) and the De-institutionalization service array services of Day Supports (provided in 2300 licensed day programs and adult day health/care programs certified under 131D), Supported Employment and Residential Supports (provided in 5600 b and c group homes, licensed 5600(f) AFLs, and unlicensed AFLs).
- CAP/DA waiver included Coordinated Caregiving Effective, 2019. Effective January 2019, providers requesting to provide HCBS service must submit a Provider Self-Assessment and be Fully integrated and fully compliant with HCBS final rule before providing services.
- Through this internal review and assessment of waiver services and settings, North Carolina determined that no services under the CAP/C waiver or foster care settings would be affected by the HCBS Final Rule as the services are based in the home.
- Foster Care settings will not need to be assessed for compliance with the settings criteria if Medicaid is only funding non-residential HCBS for an individual and the unrelated caregiver (i.e., foster parent) is not paid for providing an HCBS service to the individual. After additional assessment and review of foster care in North Carolina, the state determined foster care settings will not need to be assessed for compliance with the settings criteria as foster care is not an HCBS waiver service, foster care must be provided in "…the private residence of one or more individuals…" (NC G.S. § 131D-10.2.), and foster parents are not paid for providing HCBS services.
- It is presumed that individual, privately-owned homes meet all aspects of the HCBS Final Rule.
- Please note, any modification HCBS settings criteria must be supported by a specific assessed need and justified in the person-centered plan.

Structure of Waiver Oversight in North Carolina

North Carolina Innovations and NC MH/IDD/SAS Health Plan

The North Carolina Innovations waiver program is a 1915(c) waiver that is operated with the NC MH/IDD/SAS Health Plan, which is a 1915(b) waiver. The waiver is managed by six Prepaid Inpatient Health Plans (PIHPs), which are referred to as LME/MCOs, in specified geographic areas of the State. These LME/MCOs operate under contracts with the Division of Health Benefits (DHB) for the management of Medicaid mental health, intellectual/developmental disability, and substance abuse services for beneficiaries three years old and older. They also operate under contracts with the DMH/DD/SAS for the management of State funded mental health, intellectual/developmental disability, and substance abuse services. The LME/MCOs manage their own provider networks and will have direct oversight over the assessment of HCBS for their providers and monitoring activities.

CAP/DA, CAP/Choice, CAP/C

The CAP/DA waiver and its self-directed model CAP/Choice, and the CAP/C waiver are 1915(c) waivers that are operated in a Fee- for-Service (FFS). Local Lead Agencies provide case management and utilization management to the individuals that are served in their catchment. Division of Health Benefits (DHB) will have direct accountability over the assessment of HCBS for their providers, but the Local Lead Agencies will monitor the providers.

History of HCBS in North Carolina

In 2012, two waivers for individuals with IDD existed. The first waiver was the Community Alternatives Program for Individuals with Intellectual and Developmental Disabilities (CAP-I/DD). The second waiver was Cardinal Innovations waiver (which has since become the North Carolina Innovations waiver). During the course of renewing the CAP-I/DD waiver and expanding the North Carolina Innovations waiver, DHHS had conversations with CMS around the "draft" HCBS Final Rule and how it could be incorporated into the waivers. The following language was added to the waivers but applied only to licensed

"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

- Telephones must be accessible by residents 24/7/365
- Operation assistance must be available if necessary
- Telephones must be private
- Residents are permitted to have and maintain personal phones in their rooms

Visitors

- Visitors must be allowed at any time 24/7/365
- Visitors do not require facility approval (although facility may require visitors to sign in or notify the facility administrator that they are in the facility)
- Visitors must not have conduct requirements beyond respectful behavior toward other residents

Living Space

- No more than two (2) residents may share 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
- Residents must have the ability to work with the facility to achieve the closest optimal roommate situations
- Residents must have the ability to lock the rooms
- Residents must be allowed to decorate and keep personal items in the rooms (decorations must conform to safety codes and licensure rules)
- Residents must be able to come and go at any hour
- Residents must have an individual personal lockable storage space available at any time.
- Residents must be able to file anonymous complaints
- Residents must be permitted to have personal appliances and devices in their rooms (where these appliances do not violate safety codes and licensure rules)

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 and people chosen by the individual to attend care plan meetings

- Provide the appropriate support(s) to ensure 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 to be updated on a continuous basis

Food, Meal(s), and Storage of Food Access

- Resident must have access to food, meal(s), and storage of food 24/7/365
- 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 and pursuing individual activities of interest
- Residents must be allowed to choose with whom and when to participate in recreational activities

Community Activities

- Residents must be given the opportunity to take part in community activities of their choosing
- Residents must be encouraged and supported to remain active in their community
- Residents must be supported in pursing activities of interest and not be restricted from participating in community activities of their choosing

Community Integration

- Only in settings that are home and community based, integrated in the community, provide meaningful access to the community and community activities, and choice about providers, individuals with whom to interact, and daily life activities."

At the time, the waivers allowed for individuals to receive services in large congregate settings called Adult Care Homes (ACH) and group homes on the grounds of ICF-IID facilities.

DHHS identified all individuals in facilities that were:

- larger than six beds, but classified as group homes, or
- classified as Adult Care Homes, or
- on the grounds of an ICF-IID facility.

For homes that were larger than six beds, but classified as group homes, DHHS required those facilities to attest to meeting the HCBS characteristics as outlined in the waivers if they desired to continue enrollment as waiver providers. If a facility chose not to attest, the individual had the choice to remain in that setting and withdraw from the waiver or move to a waiver compliant site. For individuals in Adult Care Homes, the individual could choose to reside there and receive waiver services outside the facility as long as the facility attested to meeting the characteristics; however, Adult Care Homes were removed as a provider type for the provision of waiver services in 2012. Individuals who resided on the grounds of an ICF-IID facility had the choice to remain in that setting and withdraw from the waiver or move to a waiver compliant site. When the transition occurred to the Innovations waiver, individuals were required to live in private homes, with their families, or in living arrangements with 6 beds or less (with the exception of four 5600 group homes that were grandfathered in from the CAP IDD waiver. This transition was completed effective April 1, 2013.

As a result of this history, DHHS began the HCBS Final Rule process without waiver services being provided in residential settings on the grounds of ICF-IID facilities or in Adult Care Homes.

In North Carolina's current waivers, language was amended to specify that waiver amendments or renewals will be subject to any provision or requirement included in the state's most recent and approved Statewide Transition Plan and that HCB settings must be compliant with standards outlined in the HCBS settings rule. In addition, as outlined within this Statewide Transition Plan, HCBS Final Rule requirements apply to all identified HCBS settings regardless of licensure status.

Non-Disability Specific Settings

HCBS Final Rule requires the setting to be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. In the current waivers, the only services that are provided in disability specific settings are Day Supports, Adult Day Health and Residential Supports (though Residential Supports is also provided in Alternative Family Living arrangements which are not disability specific. The majority of waiver services are provided in private homes and the community. The Innovations waiver also offers a service called Community Networking which is provided only in integrated environments, or for self-advocacy groups and conferences. Not only does it provide for support to be in these environments, but it will pay for integrated classes/conferences and for fees for memberships so that individuals may attend such classes. The choice of waiver services is that of the individual. Additional changes to the Innovations waiver in a technical

amendment effective 11/1/16, included a requirement that individuals 16 years of age and older who are accessing Day Supports for the first time must be educated on the alternatives to this service; the addition of Supported Living which provides services to individuals who choose to rent or own their own home; and changes in the Assistive Technology definition to allow greater access to smart home technology to assist individuals in living more independently; and updating the language in the definition to eliminate the requirements that services must start or end at the Day Supports site. It notes that the individual must go to the site once per week unless waived by the LME/MCO. This encourages more community engagement outside of the facilities.

Individual/Private Homes:

DHHS presumes that Individual, privately owned homes meet all components of the HCBS Final Rule, which was presented in the technical assistance call with CMS on 6/14/16. The rights and protections of North Carolina General Statute, North Carolina Administrative Code, and the waiver apply to individuals in their private homes. Individuals in their private homes receive Care Coordination at least quarterly. Individuals in their private homes receive Care Coordination monthly if they receive services by a relative/guardian that resides with them or if they are self-directing their services. Any concerns with the individual's rights would be reported to the LME/MCO or the Local Lead Agency (LLA).

Stakeholder Engagement

HCBS Stakeholder Advisory Committee

In Spring 2014, conversations about the HCBS Final Rule began 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. DHHS 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 DHHS staff to support the HCBS Stakeholder Advisory Committee.

The initial HCBS Stakeholder Advisory Committee's composition follows.

Advocates and Stakeholders

Anna Cunningham, Advocate
Jean Anderson, Stakeholder Engagement Group for Medicaid Reform/Advocate
Kelly Beauchamp, Advocate
Kelly Mellage, Advocate
Sam Miller, NC Council on Developmental Disabilities/Family Member (until December 2015)
Nessie Siler, NC Council on Developmental Disabilities/Self-Advocate
Johnathan Ellis, Self-Advocate
Yukiko Puram, Advocate (until March 2018)
Sue Guy, State Consumer Family Advisory Committee (SCFAC)
Benita Purcell, State Consumer Family Advisory Committee (SCFAC) (began July 2016)
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 (DRNC)
Kelly Friedlander, North Carolina Stakeholder Engagement Group (NC SEG) (until December 2016)

Provider Organizations and Agencies

Peggy Terhune, Ph.D., Monarch, Inc. (Provider)
Bridget Hassan, Easter seals UCP (Provider)
Melissa Baran, Enrichment Arc (Provider) (until October 2016)
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, Trillium Health Resources (formerly East Carolina Behavioral Health)
Andrea Misenheimer, Cardinal Innovations Healthcare Solutions
Christina Dupuch, Vaya Health (formerly Smoky Mountain LME/MCO)
Foster Norman, Coastal Care (until June 2015)

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 Health Benefits (DHB)
Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS)
Division of Health Service Regulation (DHSR)
NC Council on Developmental Disabilities
Division of Aging and Adult Services (DAAS)
Division of Social Services (DSS)
Division of State Operated Healthcare Facilities (DSOHF)

Community Outreach

Website

To ensure consistent, clear, and streamlined communication with waiver beneficiaries, families, provider organizations, associations, and 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	January 26, 2015 – October. 5, 2015	35
Self-Assessment Page	January 26, 2015 – October. 5, 2015	27
Provider Self-Assessment	January 26, 2015 – October. 5, 2015	16
Public Notice & Comments	January 26, 2015 – October. 5, 2015	12
Listening Sessions	January 26, 2015 – October. 5, 2015	3
Plan Submission	January 26, 2015 – October. 5, 2015	2
Vision	January 26, 2015 – October. 5, 2015	1

Total of 29,562-page views

This source provides information and links focused solely on the implementation of the HCBS Final Rule including the HCBS Final 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 ongoing 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 were also posted at www.ncdhhs.gov/hcbs/index.html. The website was updated to include public comments from the 30-day posting period and the initial submission of the plan to CMS. It will continue to be updated along with the plan and when self-assessment data are available.

Other communication included:

- Stakeholder Listening 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)
- PowerPoint presentations
- Blog post
- Twitter postings
- A weekly Q&A throughout the self-assessment process

The DHHS 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' 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), and 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, 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 well-informed individuals and families. The Stakeholder Engagement Group also organized a series of Consumer and Family Community Chats on the HCBS rule in response to feedback from the public forum held January16, 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. DHHS leadership met with attendees where heartfelt personal experiences were shared about the system, services, and what needs to occur as North Carolina implements the transition plan. The Stakeholder Engagement Group hosted five 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 regarding the HCBS Final Rule and the process for achieving compliance. The DHHS also offered to engage with each of the stakeholder groups of the nine LME/MCOs (that have since merged to seven), and the Local Lead Agencies. The ongoing dynamic of these partnerships will continue to evolve throughout the pilot assessment, self-assessment, monitoring, and ongoing compliance phases of plan implementation. DHHS developed the draft plan and the proposed Provider Self-Assessment 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 Consumer and Family Advisory Committees (CFAC) 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. Individuals shared personal experiences with services, helping DHHS to identify needs as North Carolina implements the transition plan.

Plan Posting

The initial plan, as submitted, was posted to the North Carolina DHHS website www.ncdhhs.gov/hcbs/index.html. Additional information, including questions from and responses to CMS are also posted on website.

Listening Sessions

During the public comment period, DHHS hosted 11 listening sessions Statewide. In these meetings, DHHS shared information regarding the HCBS Final Rule, 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 Feb. 12, 2015. The Sessions were for the primary purpose of "listening" to beneficiaries and their families. To aid in the facilitation of the meetings, a PowerPoint presentation was used along with wall charts depicting input as it was received. In addition, consumer/family friendly materials were available to assist with gleaning as much feedback as possible. All of these efforts have helped DHHS finalize a plan that clearly meets intent according to the voices of its recipients. Special consideration was given to determine the specific locations 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 DHHS that any change in policy should occur following the Listening and Chat Sessions, as the voice of our beneficiaries is paramount to establish policy as it relates to the implementation of this Plan and to improve real life outcomes and system-wide accountability. "Nothing about me without me" was voiced by beneficiaries throughout Statewide reform efforts and again throughout the Listening Sessions.

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 comments and listening sessions included:

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

Initial Public Comment

DHHS posted the transition plan and proposed self-assessment at www.ncdhhs.gov/hcbs/index.html for a 30-day public comment period from January 21, 2015. Notice of the public comment period was announced through the dedicated 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 Spanish as requested; and public verbal presentations inclusive of interpreters for Individuals who were deaf or hard of hearing.

Releasing the plan for comment ensured that all stakeholders were fully informed of DHHS' plan for meeting the HCBS Final Rule. Feedback and comments were accepted in the following ways:

- **By email:** HCBSTransPlan@dhhs.nc.gov
- **By written comments to:**
  NC DHHS
  ATTN: HCBS Transition Plan

3015 Mail Service Center
Raleigh, NC 27699-3015

- **By FAX:** 919-508-0975 (please include ATTN: HCBS Transition Plan in the subject line)

At the conclusion of the Listening Sessions, information was captured in an "at-a-glance" format, shared with the broader stakeholder community, and posted to the dedicated website. Public comments are maintained by DHHS.

Initial Public Comment Analysis

THE HCBS Worksheet Analysis, inserted below, is a synopsis of the narrative feedback received during the comment period. Note that each point of feedback is individually counted specific to affiliation (e.g., one person could have 20 points), and each is counted as a separate entity.

	SOURCE BREAKDOWN					
	EMAIL	**PHONE**	**CORRESP ON-DENCE**	**FAX**	**SESSION ATTENDE ES**	**TOTAL OF ALL**
GRAND TOTALS	**308**	**0**	**0**	**6**	**323**	**637**
Stakeholders	76	0	0	0	304	380
Percent of Source Group	24.7%	0.0%	0.0%	0.0%	94.1%	59.7%
Advocacy Groups	99	0	0	0	0	99
Percent of Source Group	32.1%	0.0%	0.0%	0.0%	0.0%	15.5%
Providers/Provider Orgs.	40	0	0	6	19	65
Percent of Source Group	13.0%	0.0%	0.0%	100%	5.9%	10.2%
LME/MCOs/LLAs	4	0	0	0	0	4
Percent of Source Group	1.3%	0.0%	0.0%	0.0%	0.0%	0.6%
Stakeholder Committee	89	0	0	0	0	89
Percent of Source Group	28.9%	0.0%	0.0%	0.0%	0.0%	14.0%
State Government	0	0	0	0	0	0

Percent 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
Percent of Source Group	64.4%	53.3%	59.7%
Advocacy Groups	59	40	99
Percent of Source Group	16.2%	14.7%	15.5%
Providers/Provider Orgs.	25	40	65
Percent of Source Group	6.8%	14.7%	10.2%
LME/MCOs/LLAs	4	0	4
Percent of Source Group	1.1%	0.0%	0.6%
Stakeholder Committee	42	47	89
Percent of Source Group	11.5%	17.3%	14.0%
State Government	0	0	0
Percent of Source Group	0.0%	0.0%	0.0%

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

Second Public Comment

DHHS posted the transition plan and proposed self-assessment at www.ncdhhs.gov/hcbs/index.html for a 30-day public comment period from November 17, 2016. Notice of the public comment period was announced through the dedicated DHHS website, LME/MCO/Local Lead Agency outreach, and face to face communications via provider organizations and the broader stakeholder community. The public comment period provided interactive opportunities for dialogue with all vested partners. Feedback and comments were accepted in the following ways:

- **By email:** HCBSTransPlan@dhhs.nc.gov
- **By written comments to:**
  NC DHHS
  ATTN: HCBS Transition Plan
  3015 Mail Service Center
  Raleigh, NC 27699-3015
- **By FAX:** 919-508-0975 (please include ATTN: HCBS Transition Plan in the subject line)
- **By Calling:** 1-866-271-4894 – North Carolina Community Resource Connection Customer Line

Releasing the updated plan for comment ensured that all stakeholders were fully informed of DHHS' plan for meeting the HCBS Final Rule. Public comments are maintained by DHHS.

Second Public Comment Analysis

THE HCBS Worksheet Analysis, inserted below, is a synopsis of the narrative feedback received during the comment period. Note that each point of feedback is individually counted specific to affiliation, e.g., one person could have 20 points, and each is counted as a separate entity.

	EMAIL	PHONE	CORRESP ON-DENCE	FAX	TOTAL OF ALL
GRAND TOTALS	**29**	**0**	**0**	**6**	**29**
Stakeholders	3	0	0	0	3
Percent of Source Group	10.3%	0.0%	0.0%	0.0%	10.3%
Advocacy Groups	0	0	0	0	0

Percent of Source Group	0.0%	0.0%	0.0%	0.0%	0.0%
Providers/Provider Orgs.	3	0	0	6	3
Percent of Source Group	10.3%	0.0%	0.0%	100%	10.3%
LME/MCOs/LLAs	0	0	0	0	0
Percent of Source Group	1.3%	0.0%	0.0%	0.0%	0.0%
Stakeholder Committee	23	0	0	0	23
Percent of Source Group	79.3%	0.0%	0.0%	0.0%	79.3%
State Government	0	0	0	0	0
Percent of Source Group	0.0%	0.0%	0.0%	0.0%	0.0%

	ACCEPT/CONSIDER BREAKDOWN		
	ACCEPT - A	**CONSIDER - C**	**TOTAL OF ALL**
GRAND TOTALS	**5**	**24**	**29**
Stakeholders	0	3	3
Percent of Source Group	0.00%	12.5%	10.3%
Advocacy Groups	0	0	0
Percent of Source Group	0.00%	0.00%	0.00%
Providers/Provider Orgs.	1	2	3
Percent of Source Group	20.0%	8.3%	10.3%
LME/MCOs/LLAs	0	0	0
Percent of Source Group	0.00%	0.0%	0.00%

Stakeholder Committee	4	19	23
Percent of Source Group	80.0%	79.2%	79.3%
State Government	0	0	0
Percent of Source Group	0.0%	0.0%	0.0%

Third Public Comment

DHHS posted the transition plan and proposed self-assessment at www.ncdhhs.gov/hcbs/index.html for a 30-day public comment period from May 25, 2018. Notice of the public comment period was announced through the dedicated DHHS website, LME/MCO/Local Lead Agency outreach, and face to face communications via provider organizations and the broader stakeholder community. The public comment period provided interactive opportunities for dialogue with all vested partners. Feedback and comments were accepted in the following ways:

- **By email:** HCBSTransPlan@dhhs.nc.gov
- **By written comments to:**
  NC DHHS
  ATTN: HCBS Transition Plan
  3015 Mail Service Center
  Raleigh, NC 27699-3015
- **By FAX:** 919-508-0975 (please include ATTN: HCBS Transition Plan in the subject line)
- **By Calling:** 1-866-271-4894 – North Carolina Community Resource Connection Customer Line
- There is “no wrong door” for submitting feedback/input.

Releasing the updated plan for comment ensured that all stakeholders were fully informed of DHHS’ plan for meeting the HCBS Final Rule. Public comments are maintained by DHHS.

Third Public Comment Analysis

THE HCBS Worksheet Analysis, inserted below, is a synopsis of the narrative feedback received during the comment period. Note that each point of feedback is individually counted specific to affiliation, e.g., one person could have 20 points, and each is counted as a separate entity.

	EMAIL	PHONE	CORRESPON-DENCE	FAX	TOTAL OF ALL
GRAND TOTALS	**30**	**0**	**0**	**6**	**30**
Stakeholders	0	0	0	0	0
Percent of Source Group	0%	0.0%	0.0%	0.0%	0%
Advocacy Groups	0	0	0	0	0
Percent of Source Group	0.0%	0.0%	0.0%	0.0%	0.0%
Providers/Provider Orgs.	25	0	0	6	25
Percent of Source Group	83.3%	0.0%	0.0%	100%	83.3%
LME/MCOs/LLAs	3	0	0	0	3
Percent of Source Group	10%	0.0%	0.0%	0.0%	10%
Stakeholder Committee	0	0	0	0	0
Percent of Source Group	0%	0.0%	0.0%	0.0%	0%
State Government	2	0	0	0	2
Percent of Source Group	6.7%	0.0%	0.0%	0.0%	6.7%

	ACCEPT/CONSIDER BREAKDOWN		
	ACCEPT - A	CONSIDER - C	TOTAL OF ALL
GRAND TOTALS	**20**	**10**	**30**
Stakeholders	0	0	0
Percent of Source Group	0.00%	0.00%	0.00%
Advocacy Groups	0	0	0

Percent of Source Group	0.00%	0.00%	0.00%
Providers/Provider Orgs.	19	6	25
Percent of Source Group	95.0%	60.0%	83.3%
LME/MCOs/LLAs	0	3	3
Percent of Source Group	0.00%	30.0%	10.0%
Stakeholder Committee	0	0	0
Percent of Source Group	0.00%	0.00%	0.00%
State Government	1	1	2
Percent of Source Group	5.0%	10.0%	6.7%

Additional data are also contained within this worksheet and are available for reference. Public comments received through email, handwritten correspondence, fax, testimony, and input from the 11 listening sessions, were analyzed and incorporated as deemed necessary by DHHS staff. The updated plan was finalized January 2017.

DHHS seeks to ensure wide internet-based access; therefore, dedicated web pages with the same information were posted to the Division of Health Benefits (DHB) (https://medicaid.ncdhhs.gov/) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (www.ncdhhs.gov/mhddsas/providers/IDD/index.htm) websites.

Moving Forward

DHHS, 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 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 who wants 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 its role, while the partnership with the NC Stakeholder Engagement Group will funnel into DHHS' work - ongoing broad-based input from the greater community of individuals receiving waiver supports.

HCBS Stakeholder Educational and Trainings Activities

DHHS and LME/MCOs will be offering technical assistance (e.g., webinars, onsite visits to providers and LME/MCOs, as needed, tele-conferences, expansion of the Statewide Training, as needed, use of the "HCBSTransPlan" designated email for immediate response to questions and inquiries, continued updates to the designated HCBS website to facilitate an active and up to date flow of information) as needed during this process. Some additional examples include the provision of training to LME/MCOs/Local Lead Agencies and stakeholders on guardianship, updates from SOTA calls, etc., and the establishment of protocols for the LME/MCOs/DHB/Local Lead Agencies to share with networks and providers. This effort will also include involvement of the HCBS Stakeholders and strategic workgroups that have been instrumental in the rollout and implementation of the HCBS Final Rule in North Carolina. DHB, DMH/DD/SAS and LME/MCOs have presented on HCBS at the following conferences:

- NC Provider Council – September 15, 2015
- NCARF – April 30, 2015, and October 2, 2015
- NC TIDE – November 3, 2015
- NC Council of Community Programs – Dec. 3, 2015
- ASERT State Policy Summit – March 23, 2016
- NCARF- April 28, 2016
- NCARF-September 16, 2016
- NCAPSE-October 7, 2016
- DWAC-March 21, 2018

DHHS worked in partnership with Disability Rights of North Carolina (DRNC) to develop a HCBS Guardianship webinar regarding guardianship, alternatives to guardianship, and HCBS. Additional webinars in development are being created and will be presented to the HCBS Stakeholder workgroup for feedback. These webinars will be posted to the HCBS website.

Assessment of System Wide Policies

North Carolina Administrative Rules and Statutes

The Division of Health Service Regulation, Division of Health Benefits (DHB), Division of Aging and Adult Services, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services reviewed regulations that could impact or be impacted by the implementation of the transition plan. See attached listing of regulations that were reviewed. Each regulation indicates one of the following:

- Compliant with HCBS: All elements support the requirements of the HCBS rule.
- Partially Compliant HCBS: Some elements may support the requirements of HCBS rule, but not all elements are present.
- Non-compliant with HCBS: At least some elements conflict with the requirements of the rule.

Meetings with DHHS Divisions who are responsible for these rules were held prior to 12/31/16. 10A NCAC 27 G. 2301(d) was determined to be out of compliance with three of the characteristics under the HCBS rule. 10A NCAC 27 G. 2301(d) reads as follows:

> The majority of the Adult Day Vocational Program activities in this model, whether vocational or developmental in nature, are carried out on the premises of a site specifically designed for this purpose.

Due to recent Competitive Integrated Employment activities. NC continues to review replacement language to bring this rule into compliance. Once language is identified and approved; the change in language will be submitted to the Rules Commission.

Pursuant to Chapter 150B of The Administrative Procedure Act subpart (d) (20) "[t]he Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)(c) Medicaid Waiver programs or amendments to existing 1915(b)(c) Medicaid Waiver programs is exempt from Rule Making and, as such, the waiver carries the full force of rule in North Carolina." (NCGS 150B-1(d)(20)). Additionally, creating and amending Clinical Coverage Policies are exempt from the regular rule making procedure as noted in Chapter 150B of The Administrative Procedure Act subpart (d) (9) "[t]he Department of Health and Human Services in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to N.C.G.S. 108A-54.2." As such, DHB Clinical Coverage Policies has the same force and effect as rule. New rules will not need to be created where the current rules are silent as long as they are addressed within the waiver and/or policy.

Waiver Policy

The following will be added to the waiver policies by 11/1/16 for the NC Innovations waiver and 7/1/19 for the CAP/DA wavier:

- Units have lockable entrance door lockable by the individual, with appropriate staff having keys to doors as needed.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Except for adding these criteria, the three waiver policies (CAP C, CAP/DA, and Innovations) are compliant with the HCBS Final Rule. Upon approval of the transition plan, the process for ensuring these standards are maintained will be incorporated into waiver policy. The policy will be put into operation through the regular DHB policy process. The changes will be added to subsequent waiver amendments and submitted to CMS for review and approval. Any change in current policy will occur through established DHHS processes which includes review by the Physician's Advisory Group and public comment.

LME/MCO/Local Lead Agency (Case Management Entity) Self-Assessment and Remediation

DHHS reviews the LME/MCO/Local Lead Agency contracts and agreements annually to determine modifications. System alignment with the HCBS Final Rule (to ensure that processes, regulations, and policy fully support the HCBS Final Rule), is the desired outcome for North Carolina.

Concurrent to the comprehensive DHHS review, LME/MCOs/Local Lead Agencies conducted self-assessments. The LME/MCO/Local Lead Agency reviewed 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 HCBS Final Rule. DHHS provided a framework for the completion of the review to maintain consistency across all agencies. Each LME/MCO/Local Lead Agency was required to identify any modifications needed to achieve compliance with the HCBS Final Rule. The DHHS HCBS Internal Team received eight LME/MCO attestations and 26 Local Lead Agencies attestations. These attestations were reviewed by The DHHS HCBS Internal Team and found to be in compliance. Additionally, a desk review of the policies and procedures are completed during the annual External Quality Review Organization review. Any deficiencies in policy will require a plan of correction by the LME/MCO. Reviews for this current fiscal year have not

shown any conflicts with the HCBS final rule. Please note that DHHS contracts with the LME/MCOs ensure 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 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).

DHHS strategically worked with the stakeholder community inclusive of Individuals receiving supports, PIHPs, providers, advocacy groups, provider organizations, etc., to ensure 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 Pilot

DHHS collaborated with stakeholders to develop a provider self-assessment tool and a comprehensive companion guide for providers to evaluate compliance with the 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.

DHHS conducted a pilot of the self-assessment to verify that the tool captured all the required waiver elements and was universally understood. The initial plan for the self-assessment involved all 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 LME/MCOs. Providers were not duplicated in the sample. The assessment was completed using an 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, 2015. There were 224 submissions from Innovations waiver providers and 13 submissions from CAP/DA and CAP/Choice.

From the pilot, DHHS determined that:

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

DHHS 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 agency site, whichever is larger. After the initial self-assessment process, individual job sites will not be required to undergo self-assessment as discussed with CMS in September. 25, 2015. All group supported employment settings are addressed with corporate site's provider self-assessments. Each corporate site should have rules, policies and procedures that are governed by HCBS standards for ensuring compliance at each site, regardless of individual or group Supported Employment.

Providers will submit self-assessments, along with the evidence of compliance, to the assigned LME/MCO or DHB CAP/DA staff on or before September 15, 2015. DHHS requested an extension to the six-month time period for assessments to be completed due to the DHHS's-published timeframe of July 15, 2015, through September 15, 2015, for the Statewide provider self-assessment process. CMS granted this three-day extension on August 25, 2015.

The DHHS HCBS Internal Team, with the LME/MCOs/Local Lead Agencies, will 1) determine if individual provider assessments are compliant with the HCBS Final 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 provider compliance. Additional evidence may be requested, or subsequent reviews conducted, as needed, to further assess and validate compliance. The Statewide assessment was completed September 15, 2015, with initial analysis completed March 31, 2016.

It is important to note that providers who were not part of the initial self-assessment process must be in full compliance prior to providing waiver services. DHB CAP/DA staff and the LME/MCOs require new providers to complete a self-assessment and ensure that services do not begin at that site until it is determined to be in full compliance.

Heightened Scrutiny

CMS has provided guidance that settings that meet the criteria below must go through the heightened scrutiny (HS) process to ensure the setting can overcome the presumption of having "qualities" of an institution:

- In a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
- located in the building on the grounds of, or immediately adjacent to, a public institution; or
- a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. (see below for additional information on page 30)

Each state makes the determination if sites that meet these criteria are submitted to CMS for review and approval to provide HCBS waiver services

- The State will not consider facilities that are in buildings that provide inpatient institutional treatment and those on the grounds of, or immediately adjacent to, a public institution for Heightened Scrutiny review.
- The State will not consider disability-specific farms and disability-specific gated communities for Heightened Scrutiny review.

The e-Review process includes a function that immediately denotes if a setting or site has the qualities of an institution. Guidance was given through the HCBS Self-Assessment Companion Document to help ensure a provider site responds accurately; specifically, as it relates to setting that may have the effect of isolating. The DHHS HCBS Internal Team also receives feedback from stakeholders if they have concerns about a setting that may isolate individuals from the greater community.

The provider self-assessment asks the following questions:

1. Is the facility one of the following?
__None
__Nursing facility
__Institution for Mental Diseases
__Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
__Hospital

2. Is the facility in one of the following locations?
__Yes __No A building that is also a publicly or privately-operated facility that provides inpatient institutional treatment?
__Yes __No A building on the grounds of, or immediately adjacent to, a public institution?
__Yes __No A setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Once identification occurs, the DHHS HCBS Internal Team engaged a process through the development of threshold assessment to determine if heightened scrutiny is warranted. The LME/MCO and DHB CAP/DA staff will share the form with the provider agency if it appears that heightened scrutiny may apply.

The provider will have ten (10) business days to complete and return the threshold assessment. Follow up will occur as indicated based on the review of the form within five business 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 desk review will be completed within five business days of the receipt of all documents submitted. If the DHHS HCBS Internal Team determines that the site may be able to overcome the institutional presumption, the site will be submitted CMS's heightened scrutiny process including a request for public comment on the setting. If the DHHS HCBS Internal Team determines that the site cannot overcome the institutional

presumption, then the team will work with the LME/MCO and CAP-DA staff, individuals and families, and providers on the transition of these individuals to sites that meet full compliance with all aspects of the HCBS rule. Please see attached Heightened Scrutiny document (see Appendix A). During the initial provider self-assessment and review, the DHHS did not identify any providers that are located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; or any settings that are in a building on the grounds of, or immediately adjacent to, a public institution. Therefore, no settings meeting the first two heightened scrutiny criteria were submitted to CMS for Heightened Scrutiny Review. There are two-day programs that are located on the grounds of a private ICF facilities, one Adult Day Health Center on the grounds of a hospital, one Supported Employment site that obtains fresh vegetables from the grounds of an ICF IID, and one site that has a three-bed group home on the same grounds as a day program. One of the day programs on the grounds of a private ICF has submitted a transition plan to close this program and transition individuals into integrated community settings. The DHHS HCBS Internal Team, following the above Heightened Scrutiny process, reviewed the other sites and the following Heightened Scrutiny determinations were made:

Site Description	Service	Location	DHHS Outcome	# of individuals Transitioned
Day program on the grounds of a farm.	Day Supports	Albemarle, NC	Provider chose not to continue providing HCBS waiver day support services at this location. Transitions completed before Heightened Scrutiny process was initiated.	8
Supported Employment on the grounds of a farm.	Supported Employment	Albemarle, NC	Provider chose not to continue providing HCBS waiver day support services at this location. Transitions completed before HS process was initiated.	7
Supported Employment site that obtains fresh vegetables	Supported Employment	Chapel Hill, NC	DHHS HCBS Internal Team determined the site could not overcome the institutional presumption. Communication issued 4/17/17 that stated	3

from the grounds of an ICF IID			individuals should be transitioned by March 16, 2018. *July 13, 2017 communication extended the transition period to March 16, 2019 – Transition completed on 09/01/2018	
Adult day health program located on ground of a private inpatient institution.	Adult Day Health	Oxford, NC	The DHHS HCBS Internal Team determined the site did not meet the Heightened Scrutiny threshold level. Communication was issued 4/24/18.	N/A
Day program on the campus of a private ICF-IID	Day Supports	Raleigh, NC	The DHHS HCBS Internal Team determined the site could not overcome the institutional presumption. Communication issued 4/24/18 that stated individuals should be transitioned by March 19, 2019.	12

Moving forward, if the State receives a request for a facility that has multiple group homes or a day program co-located, which could have the effect of isolating individuals from the broader community, the State will perform a desk review of materials to determine if the site could overcome the institutional presumption and meet HCBS characteristics. Using the Heightened Scrutiny Review Tool, the desk review will examine the provider self-assessment, Heightened Scrutiny assessment~~s~~, and additional supporting documentation (policies, site maps, schedules, etc.).

If the desk review demonstrates the site cannot overcome the institutional presumption, the site will not be put forward to CMS for Heightened Scrutiny review. Individuals will be supported to transition to an HCBS setting validated fully compliant with all aspects of the HCBS Final Rule by December 31, 2022.

If the desk review demonstrates the site could potentially overcome the institutional presumption and meet HCBS characteristics, the State will perform an onsite review to confirm information reviewed during desk review and post evidence for public comment prior to forwarding to CMS for Heightened Scrutiny review. If the onsite review shows the site cannot overcome the institutional presumption and meet HCBS, the site will not be put forward to CMS for Heightened Scrutiny review. DHHS leadership will have final determination over a site being submitted to CMS for Heightened Scrutiny review. At this time, North Carolina does not have any sites that will be submitted to CMS for HS review. If there are sites that identified during the final validation process, transitions will occur and be completed by December 31, 2022.

My Individual Experience Survey

Based on stakeholder feedback, the DHHS HCBS Internal Team created an assessment which is completed by the individual receiving waiver services. This survey is mirrored against the provider assessment; however, it is in a format that is easily understood, in person-first language, and contains graphics. The survey asks for the provider/site where individuals receive services so that the information received can inform the assessment of the provider/site. In addition to soliciting the input from the Stakeholder's group in the development of the "My Individual Experience" survey (MIE), the DHHS HCBS Internal Team also enlisted the assistance of DHHS's Americans with Disabilities Act (ADA) Statewide Coordinator, who has a background in developing materials for people with IDD as well working with grassroots advocacy groups promoting the inclusion of people with disabilities. People with IDD and their families have been engaged in vetting the document and their feedback has been incorporate into the survey. The DHHS believes this is a critical part of the process in order to yield valuable insights to the services provided. The "My Individual Experience" survey reflects the following statement: "A family member, guardian or care coordinator may help you. Your service provider may NOT help you. Anyone helping you should do all that they can to tell us what YOU think. The way YOU see your life will help us make your waiver services better for you." This statement is designed to promote as much independence as possible for the individual receiving the service to complete the survey.

There are four separate surveys for the "My Individual Experience" survey: Adult Day Health, Day Supports, Residential Supports and Supported Employment. A representative sample (per service) of individuals was chosen to take part in the MIE during fall of 2016. To determine the sample size for the survey per service, DHB CAP/DA staff and the LME/MCOs will use Raosoft (http://www.raosoft.com/samplesize.html). DHB CAP/DA staff and the LME/MCOs will use RatStats (https://oig.hhs.gov/compliance/rat-stats/) to determine the sample. This information will be used to validate the responses to the provider self-assessment. Annually, and thereafter, a representative sample of individuals will be chosen to participate each year based on the number of individuals served in each service per LME/MCO and Local Lead Agency. Through this portion of the monitoring process, feedback will be available to Local Lead Agencies, the LME/MCOs and the providers. The MIE is posted on the HCBS website so that individuals who are not chosen as part of the representative sample may also submit an assessment. The initial roll out of the MIE was from 8/25/16 through 10/7/16; however, the end date was extended to allow for a greater response to be received. As of May 1, 2018, a total of 2473 surveys had been received. By services, they are as follows:

Service Type	2016	2017	2018
Adult Day Health	38	46	113
Day Supports	298	742	733
Residential	279	306	1330
Supported Employment	113	130	297
Total	**728**	**1224**	**2473**

A series of 'threshold' questions have been identified in each survey. If these questions are all answered in a manner that is non-compliant by HCBS standards, the survey will be flagged and the DHHS HCBS Internal Team, LME/MCO and DHB CAP/DA staff will be alerted to follow up. The DHHS HCBS Internal Team has provided a standardized series of follow up questions to be used in the follow up process if the survey is flagged and a template for reporting findings and follow up actions has been provided to the LME/MCOs and DMS CAP/DA staff.

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

Provider Self-Assessment

Data Analysis

As of May 2018, 4,538 providers have achieved a status of 'Full Integration'.

Each question is rated as Full Integration, Emerging Integration, Insufficient Integration, and additional information needed. We chose to use the term 'integration' instead of 'compliance' because we wanted assessment of the 'integration' of the HCBS rule into the policies, procedures, and actions of the provider. The DHHS HCBS Internal Team chose not to use the word 'compliance' to dissuade the provider to 'just check the box' to be compliant but wanted integration and the HCBS philosophy to be part of the service system. Please note that the Self-Assessment Review Guide used by DHB CAP/DA staff and the LME/MCOs outlines the

expectations of Full Integration/Full Compliance, Emerging Integration/Partial Compliance, Insufficient Integration/Non-Complaint and Additional Information Needed.

Assessments in System January 2016

Services	Assessments Submitted
Adult Day Health	46
(b)(3) Supported Employment	225
(b)(3) De-institutionalization (DI) Services	14
Day Support	345
Residential Supports	2,512
Supported Employment	762
Total	**3,904**

Assessments in System January 2017

Services	Emerging	Fully Integrated	Totals
Adult Day Health	12	38	50
(b)(3) Supported Employment	109	289	398
(b)(3) DI Services	20	16	36
Day Support	94	285	379
Residential Supports	891	2397	3288
Supported Employment	235	571	806
Total	**1,361**	**3,596**	**4,957**

Assessments in System May 2018

Services	Emerging	Fully Integrated	Totals
Adult Day Health	12	38	50
(b)(3) Supported Employment	110	305	415
(b)(3) DI Services	28	27	55
Day Support	101	336	437
Residential Supports	1,087	3,210	4,297

Supported Employment	254	623	877
Total	**1,592**	**4,538**	**6,131**

Assessments with Ratings from LME/MCOs & DHB CAP/DA

Question 1: The setting is integrated in and supports full access to the greater community (work, live, recreate and other services). There are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS:

- Are transportation and other supports provided so that people can regularly access services similar to those used by the community at large?
- Can people regularly interact directly with other members of the community who are not paid to do so?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	46	0	46
(b)(3) Supported Employment	0	8	217	0	225
(b)(3) DI Services	0	4	10	0	14
Day Support	0	16	327	1	344
Residential Supports	0	349	2162	1	2512
Supported Employment	0	98	662	2	762
Total	**0**	**475**	**3424**	**4**	**3903**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	44	0	45

(b)(3) Supported Employment	0	7	219	0	226
(b)(3) DI Services	0	46	724	0	771
Day Support	0	20	325	1	346
Residential Supports	0	249	2510	1	2760
Supported Employment	0	46	724	1	771
Total	**0**	**325**	**3884**	**3**	**4172**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	44	0	44
(b)(3) Supported Employment	0	1	414	0	415
(b)(3) DI Services	0	2	53	0	55
Day Support	0	10	427	0	437
Residential Supports	0	110	4186	1	4297
Supported Employment	0	18	859	0	877
Total	**0**	**147**	**5983**	**1**	**6131**

Question 2: The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

- The setting is selected by people from among residential and day options that include generic settings.
- Do individuals choose their rooms (if residence) or the area they work in, etc.?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	2	44	0	46
(b)(3) Supported Employment	0	5	220	0	225
(b)(3) DI Services	0	2	12	0	14
Day Support	0	43	299	1	343
Residential Supports	0	385	2127	0	2512
Supported Employment	0	76	685	1	762
Total		**513**	**3387**	**2**	**3902**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	44	0	45
(b)(3) Supported Employment	0	7	219	0	226
(b)(3) DI Services	0	2	22	0	24
Day Support	0	20	325	1	346
Residential Supports	0	249	2510	1	2760
Supported Employment	0	46	724	1	771
Total	**0**	**325**	**3844**	**3**	**4172**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total

Adult Day Health	0	5	45	0	50
(b)(3) Supported Employment	0	3	412	0	415
(b)(3) DI Services	0	2	53	0	55
Day Support	0	43	394	0	437
Residential Supports	0	195	4101	1	4297
Supported Employment	0	53	824	0	877
Total	**0**	**302**	**5829**	**1**	**6131**

Question 3: Ensures the rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Do people have the space and opportunity to speak on the phone, open and read mail, and visit with others, privately?
- Do people have a place and opportunity to be by themselves during the day?
- Is informed consent obtained prior to implementation of intrusive medical or behavioral interventions?
- For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?
- For people using psychotropic medications, is the use based on specific psychiatric diagnoses?
- Do people receive the fewest psychotropic meds possible, at the lowest dosage possible?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	26	0	26
(b)(3) Supported Employment	0	15	210	0	225
(b)(3) DI Services	0	5	9	0	14
Day Support	0	36	307	1	344
Residential Supports	0	368	2144	0	2512

Supported Employment	0	107	653	1	761
Total	**0**	**531**	**3349**	**2**	**3882**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	45	0	45
(b)(3) Supported Employment	0	14	212	0	226
(b)(3) DI Services	0	5	19	0	24
Day Support	0	19	326	1	346
Residential Supports	0	219	2540	0	2759
Supported Employment	0	45	722	1	771
Total	**0**	**305**	**3864**	**2**	**4171**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	50	0	50
(b)(3) Supported Employment	0	2	413	0	415
(b)(3) DI Services	0	1	54	0	55
Day Support	0	7	430	0	437
Residential Supports	0	69	4228	0	4297
Supported Employment	0	10	867	0	877
Total	**0**	**89**	**6042**	**0**	**6131**

Question 4: Optimizes, but does not regiment, independent initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

- Do people receive only the level of support needed to make their own decisions?
- Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?
- Do people choose their daily activities, their schedules, and locations of the activities?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	45	0	46
(b)(3) Supported Employment	0	11	214	0	225
(b)(3) DI Services	0	4	10	0	14
Day Support	0	26	315	1	342
Residential Supports	0	362	2145	1	2508
Supported Employment	0	103	656	1	760
Total	**0**	**507**	**3385**	**3**	**3895**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	44	0	45
(b)(3) Supported Employment	0	10	214	0	224
(b)(3) DI Services	0	3	19	0	22
Day Support	0	15	330	1	346
Residential Supports	0	222	2532	1	2755
Supported Employment	0	41	727	1	769

Total	**0**	**292**	**3866**	**3**	**4161**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	4	46	0	50
(b)(3) Supported Employment	0	2	413	0	415
(b)(3) DI Services	0	3	52	0	55
Day Support	0	11	426	0	437
Residential Supports	0	114	4182	1	4297
Supported Employment	0	13	864	0	877
Total	**0**	**147**	**5983**	**1**	**6131**

Question 5: Individuals are free and supported to control their own schedules and activities as well as have access to food at all times.

- Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being "told" what they are to do?
- Do people receive support needed to make choices about the kinds of work and activities they prefer?
- Is there evidence of personal preference assessments to identify the kinds of work and activities people want?
- Do the individuals have meals at the times and places of their choosing?
- Are snacks accessible and available at all times?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	45	0	46
(b)(3) Supported Employment	0	6	219	0	225

(b)(3) DI Services	0	0	14	0	14
Day Support	0	35	308	1	344
Residential Supports	0	345	2161	2	2508
Supported Employment	0	60	701	1	762
Total	**0**	**447**	**3448**	**4**	**3899**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	1	44	0	45
(b)(3) Supported Employment	0	4	220	0	224
(b)(3) DI Services	0	0	23	0	23
Day Support	0	17	326	1	344
Residential Supports	0	190	2562	1	2753
Supported Employment	0	32	736	1	769
Total	**0**	**244**	**3911**	**3**	**4158**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	4	46	0	50
(b)(3) Supported Employment	0	0	415	0	415
(b)(3) DI Services	0	1	54	0	55
Day Support	0	24	413	0	437
Residential Supports	0	148	4148	1	4297
Supported Employment	0	42	835	0	877

Total	**0**	**219**	**5912**	**1**	**6131**

Question 6: Facilitates choice regarding services, supports, and who provides them.

- Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.)?
- Do people select the provider from a choice of providers?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	46	0	46
(b)(3) Supported Employment	0	11	217	0	228
(b)(3) DI Services	0	7	7	0	14
Day Support	0	44	300	1	345
Residential Supports	0	366	2141	1	2508
Supported Employment	0	77	683	1	761
Total	**0**	**505**	**3394**	**3**	**3902**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	45	0	45
(b)(3) Supported Employment	0	8	216	0	224
(b)(3) DI Services	0	4	19	0	23
Day Support	0	21	322	1	344
Residential Supports	0	233	2519	2	2754
Supported Employment	0	37	731	1	769
Total	**0**	**303**	**3852**	**4**	**4159**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	3	47	0	50
(b)(3) Supported Employment	0	2	413	0	415
(b)(3) DI Services	0	2	53	0	55
Day Support	0	20	417	0	437
Residential Supports	0	135	4160	2	4297
Supported Employment	0	17	860	0	877
Total	**0**	**179**	**5950**	**2**	**6131**

Question 7: The setting is physically accessible to the individual.

- Have modifications been made to promote maximum access and use of physical environment for the person, if needed and requested?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	46	0	46
(b)(3) Supported Employment	0	5	220	0	225
(b)(3) DI Services	0	0	14	0	14
Day Support	0	11	331	3	345
Residential Supports	0	173	2334	2	2509
Supported Employment	0	40	719	1	760
Total	**0**	**229**	**3664**	**6**	**3899**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	45	0	45

(b)(3) Supported Employment	0	2	222	0	224
(b)(3) DI Services	0	0	23	0	23
Day Support	0	5	337	1	343
Residential Supports	0	99	2651	5	2755
Supported Employment	0	16	752	1	769
Total	**0**	**122**	**4030**	**7**	**4159**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health	0	0	50	0	50
(b)(3) Supported Employment	0	2	413	0	415
(b)(3) DI Services	0	1	54	0	55
Day Support	0	2	435	0	437
Residential Supports	0	56	4236	5	4297
Supported Employment	0	11	866	0	877
Total	**0**	**72**	**6054**	**5**	**6131**

Question 8: Individuals have privacy in their sleeping or living unit.

- Can the individual close and lock their bedroom door?
- Is the furniture arranged as the individual prefers and does the arrangement assure privacy and comfort?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	2	7	0	9

Residential Supports	0	949	1546	7	2502
Total		**951**	**1553**	**7**	**2511**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	3	14	0	17
Residential Supports	0	355	2388	4	2747
Total	**0**	**358**	**2402**	**4**	**2764**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	29	26	0	55
Residential Supports	0	440	3853	4	4297
Total	**0**	**469**	**3879**	**4**	**4352**

Question 9: The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has the same responsibilities and protections from eviction that tenants have under landlord/tenant law. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement or other form of written agreement in place for each HCBS Participant. The document must provide protections that address eviction processes and appeals comparable to those provided under landlord/tenant law.

- Do people have the same responsibilities that other tenants have under landlord/tenant laws?
- Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services		5	4	0	9
Residential Supports		948	1546	6	2500
Total		**953**	**1550**	**6**	**2509**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	1	16	0	17
Residential Supports	0	632	2108	1	2747
Total	**0**	**633**	**2124**	**1**	**2758**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	29	26	0	55
Residential Supports	0	1036	3254	7	4297
Total	**0**	**1065**	**3280**	**7**	**4352**

Question 10: Units have entrance doors lockable by the individual with only appropriate staff having keys to doors.

- Each person living in the unit has a key or keys for that unit.
- Is there evidence that efforts are being made to teach use of a key to anyone who does not understand how to do this?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services		3	6	0	9
Residential Supports		301	2180	3	2484
Total		**304**	**2186**	**3**	**2493**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	3	14	0	17
Residential Supports	0	661	2080	5	2746
Total	**0**	**664**	**2094**	**5**	**2763**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	32	23	0	55
Residential Supports	0	1097	3195	5	4297
Total	**0**	**2258**	**3218**	**5**	**4352**

Question 11: Individuals sharing units have a choice of roommates in the setting.

- Do people choose their roommates?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	1	6	8	0	15
Residential Supports	17	392	1977	4	2390
Total	**18**	**398**	**1985**	**4**	**2405**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	2	15	0	17
Residential Supports	0	296	2197	3	2496
Total	**0**	**298**	**2212**	**3**	**2513**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	30	25	0	55
Residential Supports	0	696	3598	3	4297
Total	**0**	**726**	**3623**	**3**	**4352**

Question 12: Individuals are free to furnish and decorate sleeping and living units.

- Does each person pick the decorative items in their own private bedroom?
- Do people living in the same unit participate in the choices of decorative items in the shared living areas of the unit?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services					0
Residential Supports		247	2250	3	2500
Total		**247**	**2250**	**3**	**2500**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	1	16	0	17
Residential Supports	0	200	2310	1	2511
Total	**0**	**201**	**2326**	**1**	**2528**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services		28	27	0	55
Residential Supports		278	4018	1	4297
Total		**306**	**4045**	**1**	**4352**

Question 13: Individuals are free to have visitors of their choosing at any time.

- Are people supported in having visitors of their own choosing and to visit others frequently?

Are people satisfied with the amount of contact they have with their friends?

2016

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services		2	7	0	9
Residential Supports		312	2185	3	2500
Total	**0**	**314**	**2192**	**3**	**2509**

2017

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	1	16	0	17
Residential Supports	0	242	2267	2	2511
Total	**0**	**243**	**2283**	**2**	**2528**

2018

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
(b)(3) DI Services	0	29	26	0	55
Residential Supports	0	369	3927	1	4296
Total	**0**	**398**	**3953**	**1**	**4352**

Provider Self-Assessment Outcomes

Provider Self-Assessments Results

NC transitional HCBS providers completed electronic Provider Self Assessments in 2018. The Provider Self-Assessment was developed for providers to attest and provide evidence of compliance and integration with HCBS Final Rule. The Provider Self-Assessment allowed NC DHHS to assess the system of compliance, identify strength and weaknesses of the HCBS delivery system, increase dialogue with the LME/MCOs about their findings, which initiated an opportunity for NC DHHS to provide technical assistance for system improvement.

Each Provider Self-Assessment question was rated as Full Integration, Emerging Integration, Insufficient Integration, and additional information needed. NC DHHS chose to use the term 'integration' instead of 'compliance to ensure the 'integration' of the HCBS final rule would be included into provider's policies and procedure. This decision was implemented to ensure characteristics of HCBS Final Rule would be operationalized in provider practice and encourage providers to integrate the HCBS philosophy into their service system. DHHS provided a Self-Assessment companion Guide to the LME/MCOs and CAP/DA (see Appendix B), which outlined the expectations of Full Integration/Full Compliance, Emerging Integration/Partial Compliance, Insufficient Integration/Non-Complaint and Additional Information Needed.

An initial review of the Provider Self-Assessments (PSAs) was completed by the LME/MCOs and Community Alternatives Programs for Disabled Adults (CAP/DA). The Companion guide assisted the reviewing entities in determining full compliance and integration with HCBS final rule. A total of 9345 PSAs were reviewed for the HCBS transitional period, 2045 assessments were not accepted due to a database cleanse removing erroneous assessments, incomplete assessments, and duplicate assessment. All inactive sites were archived in the database. 5071 sites have reached Full integration/Full compliance. 2213 sites are working toward Full integration/Full compliance through validation efforts. Provider Self-Assessments included provider sites that deliver Residential Support, Day Supports, Supported Employment, and Adult Day Health services. (see Appendix C for data)

Reviewing entities continue to work with sites that are not compliant, these sites will come into compliance no later than October 31, 2022. Reviewing entities will review policies and procedures to ensure sites are compliant with HCBS Final Rule. Sites will continue to be

validated through one of the three validation methods to ensure Full integration/Full compliance.

Remediation Plan

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 HCBS Final Rule, inclusive of timelines. This plan of action is included within the comment section of the provider assessment tool and reviewed as a part of the self-assessment. DHHS has established expectations that remediation will occur on an ongoing basis with progress reviewed at six months, one year, two years, and three years, etc. with the goal of full compliance for all providers by March 17, 2023.

In the event that a site is unable to be remediated to full compliance with all aspects of the HCBS Final Rule and therefore unable to be validated, individuals receiving an HCBS service must transition to an HCBS setting validated fully compliant with all aspects of the HCBS Final Rule by December 31, 2022. These timeframes are the maximum amount of time between reviews and providers may submit evidence of progress towards compliance at any time. Self-assessments are to be submitted with plans of action to show remediation the provider will implement to ensure full compliance with all aspects of the HCBS Final 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 LME/MCO or Local Lead Agency. Acceptance indicates that the information as presented has been reviewed and the plan to meet all aspects of the HCBS Final Rule is sufficient. Technical assistance will be provided throughout the process. The e-Review tool has an operational function that will facilitate the tracking/monitoring of the plans of action and correspondence between the provider and the LME/MCO. Reviewing entities will adhere to the thresholds established in the plan and will be submitting ongoing analysis to the DHHS HCBS Internal Team. All reviews can be accessed by the DHHS HCBS Internal Team throughout any phase of this process, thus making it seamless, streamlined, and manageable in real time by all parties.

If the LME/MCO or DHB CAP/DA staff requests a self-assessment or follow-up information and does not receive the information via the web tool, then the LME/MCO or DHB CAP/DA staff will reach out to the provider by phone or email and ask for the information to be provided within five business days. If the LME/MCO or DHB CAP/DA staff receives no response within

five business days, written correspondence will be sent to the provider. If a response is not received within ten days of the correspondence being sent, the LME/MCO or DHB CAP/DA staff will assume that the provider is not interested/unwilling to come into compliance with the HCBS Final Rule.

Providers That Are Unable or Unwilling to Comply

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 thirty-day deadline from date of issuance to conform fully. If compliance does not occur within thirty days, the provider will be prohibited from providing the service in question at that site until such time there is full compliance with the HCBS Final 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 use 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 HCBS Final Rule.
2) Facilitate the seamless transition of individuals supported to an appropriate provider so there is no service interruption.

If a provider is unable to come into full compliance, all beneficiaries will receive a minimum sixty-day notice before being relocated to a site that is in compliance with the HCBS Final Rule (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 and DHB CAP/DA staff. Assigned LME/MCO or Local Lead Agency, DHB CAP/DA staff and the DHHS HCBS Internal Team will schedule a face-to-face visit with beneficiaries and their guardians (with subsequent visits occurring based on the specific needs of the individual) as soon as possible, but no later than fourteen days after becoming aware that a new service option needs to be pursued. The discussion will include the transition process and ensure the individual and family has been fully informed of any applicable due process rights.

The DHHS HCBS Internal Team in partnership with the LME/MCOs/Local Lead Agencies, will ensure there is transitional support for the beneficiaries and their family during the transition process. However, individuals may choose to remain in the setting and decline waiver services, and their choice will be respected. All notices of relocation will be issued by October 31, 2022. The appropriate parties will ensure that the individual is making a fully informed choice and decision. Person-Centered Planning meetings will be held as determined by the individuals and their team. Transition should be complete by December 31, 2022. The DHHS HCBS Internal Team will monitor the transition of individuals monthly until the transition is complete. The LME/MCOs/Local Lead Agencies, and the DHHS HCBS Internal Team will oversee all necessary transition processes.

In March 2022, NC DHHS requested reviewing entities to conduct an intermittent quarterly validation review of sites unable or unwilling to comply. NC DHHS requested these sites be identified and evaluated for service delivery; focusing on providers intent to comply with HCBS and the identification of individual receiving HCBS in those sites. The updated quarterly validation reports were submitted on April 15, all sites identifying as unable or unwilling to comply were identified as sites no longer providing services. Therefore, these sites were not providing services to individuals receiving HCBS. As of May 31, 2022, the department has confirmed there are not individuals receiving HCBS services in sites unable or unwilling to comply. All sites providing HCBS services have indicated an intent to be in compliance with HCBS Final Settings Rule .

Integration Review

Analysis of the self-assessment data from the LME/MCOs and Local Lead Agencies was submitted to the DHHS HCBS Internal Team for review by March 31, 2016. The DHHS HCBS Internal Team has reviewed this data. This analysis included information on providers that are unable to meet the HCBS Final Rule, those that are at risk for not meeting the HCBS Final Rule, and information on the status (full or emerging integration) of the remainder of the providers by characteristic. This information is based on the assessments that were accepted by the LME/MCO and DHB CAP/DA staff.

Acceptance of the assessment indicates that the information submitted by the provider is either in full compliance with all aspects of the HCBS Final Rule or that the action plans to come into compliance were sufficient. During the transition period, providers that are not in full compliance with the HCBS Final Rule will receive ongoing Technical Assistance (TA) as needed with progress reviewed at six months, one year, two years and three years, and each year with the goal of full compliance for all providers by March 17, 2023 . In the event

that a site is unable to be validated (the setting is unable to meet full compliance with all aspects of the HCBS Final Rule) individuals receiving an HCBS service must transition to a setting validated compliant with all aspects of the HCBS Final Rule by 12/31/2022.

Validation Process

The DHHS HCBS Internal Team in collaboration with LME/MCOs and DHB CAP-DA staff will assure that at least one validation strategy is used to validate provider self-assessments. To validate is to confirm the accuracy of provider self-assessments, in conjunction with the lived experience of the beneficiary, meets compliance with all aspects of the HCBS Final Rule by March 17, 2023. All HCBS settings identified within the transition period (established prior to December 31, 2018) must be validated compliant with all aspects of the HCBS Final Rule by at least one independent validation method. The DHHS has identified four possible methods that can be used to validate HCBS compliance with all aspects of the settings criteria. These four methods will be used to validate the provider self-assessments, plan of actions noted within the provider self-assessment, and individual experience.

Please note, the use of the term 'monitoring' refers to both periodic and ongoing review and assessment of HCBS compliance of the HCBS setting. (see Appendix D chart information)

Validation Strategies

- Face to face Care Coordination (on-site)
    - This has been in practice since 2016. The difference for LME/MCOs will be in how DHHS captures the data gained from the HCBS quarterly monitoring tab moving forward.
    - Care Coordination Tool: HCBS Quarterly Monitoring Tab will be completed quarterly and submitted to the LME/MCO quality management/provider network team for review and determination of remediation requirements. (see Appendix E)

- Desk Review
    - **Suggested Documents to Review:**
        - Provider Self-Assessment
        - Provider Policies and Procedures
        - Individual Support Plans
    - **Desk Reviews Associated with Remediation Efforts:**

        - In addition to documents noted above,
        - Care Coordination Monitoring Tools
        - Applicable MIE surveys
- Intense On-site Review
  An Intense On-site Review is triggered if:
    - There is a significant discrepancy in agency policies presented in provider self-assessment and Care Coordination tool.
    - There are concerns for potential heightened scrutiny that was noted as not meeting the threshold on the provider self-assessment. – Contact DHHS immediately.
    - Significant concern for isolation. Example: Documented use of a bus route; however, no bus route available at location.
    - *The on-site review would be completed by an alternative LME/MCO/CAP DA staff member, not the care coordinator assigned to complete monitoring.*
- Telehealth Visit
  The use of two-way real-time interactive audio and video to support monitoring when Individuals are in different physical locations.
    - **Provider Expectations During the Visit**
        - Have a secure HIPAA compliant mobile device (i.e., smartphone, tablet, laptop, other portable device) with live audio and video capabilities to allow for ease of mobility through the entire setting.
        - The LME/MCO/CAP-DA staff should make at least 1 request per visit to see other areas of the setting to observe the individual's ease of accessibility and monitoring of the entire setting.
        - To the beneficiary's ability and level of independence, the beneficiary should facilitate the call and guide the access of additional rooms in the setting as requested.
        - Staff are expected to be within view while with the beneficiary (i.e., seated beside or behind the beneficiary) during the visit. At no time should staff be located behind the device being used for the visit.
        - The individual should be supported in being as independent as possible. Staff should support the individual to answer questions only as needed.
        - The 'mute' function should never be activated during the visit.
        - Providers and site staff should continue all operations as usual.
        - The LME/MCO/CAP-DA staff reserve the right to speak with the individual alone without staff present, upon request.
        - All beneficiaries reserve the right to speak with the LME/MCO/CAP-DA staff alone without staff present, upon request.

        - In the event of any health and safety concern, the LME/MCO/CAP-DA staff should follow internal protocols to remediate the concern.
    - **Suggested Considerations**
        - The LME/MCO/CAP-DA staff should proactively interface with the provider organization and site staff to schedule telehealth visits and ensure accessibility and that all Individuals are aware of expectations.
        - The LME/MCO/CAP-DA staff should attempt to support and mitigate concerns if a mobile device is not accessible.
        - The LME/MCO/CAP-DA staff shall follow all applicable HIPAA rules.
        - Any methods to prevent any type of coercion should be considered and implemented (i.e., any person accompanying the individual should be seated next to the individual, within view).
        - For any technical difficulties (i.e., internet outage, computer issues), LME/MCOs/CAP-DA staff should default to the allowances outlined for, "Personal Computer and Webcam or Device Without Video Capabilities"
    - **Personal Computer and Webcam or Device Without Video Capabilities**
        - In the event the provider only has access to a stationary, personal computer and webcam or device without two-way real-time audio and video capabilities (i.e. landline telephone), validation of HCBS compliance may be supported by completion of the Care Coordination Monitoring tool: *HCBS quarterly monitoring tab* utilizing the available technology, submitting copies of the previous months' Care Coordination monitoring visits for all individuals receiving services at the setting, and completion of a desk review.

Tier One: Innovations

For all Innovations waiver services, DHHS will be validating sites by utilizing on-site care coordination or telehealth visits. Face to face visitation or telehealth visit occurs monthly for residential services and at least quarterly for supported employment and day supports. This practice allows on-site observation to be completed using a dedicated Care Coordination Tool: *HCBS quarterly monitoring Tab*, specific to validation. This process will begin January 2019.

1. Care Coordination Tool: HCBS Quarterly Monitoring Tab will be completed quarterly and submitted to the LME/MCO quality management/provider network team for review and determination of remediation requirements
2. DHHS has developed an *LME/MCO HCBS Validation Reporting Tool* template to capture all sites required for validation.

3. Submission will occur on the 5th day of the second month, following the end of quarter. Example: If a care coordinator completes HCBS tool on September 28th – the designated LME/MCO HCBS staff would submit quarterly report for July 1st-Sept 30th on November 5th. This will provide adequate time for LME/MCO HCBS staff to review and provide remediation instruction to provider(s). Any outstanding remediation efforts not addressed within the quarterly report, should be captured on the following report. A site is unable to be validated until all remediation efforts have been completed. Technical Assistance and Remediation Guidance is noted below.
4. All validation efforts will be completed by October 31, 2022. In the event that a site is unable to be validated compliant with all aspects of the HCBS Final Rule, individuals receiving an HCBS service must transition to an HCBS setting validated compliant with all aspects of the HCBS Final Rule by December 31, 2022.

Tier One: ADH and (b)(3) Services

Adult Day Health Services

All Adult Day Health can be validated using the following:

- CAP/DA Case Management quarterly on-site visits employing HCBS measures within monitoring tool; or
- Telehealth visits as outlined above; or
- Desk review using the HCBS Review Tool (see Appendix H)

(b)(3) Services

Note: A single provider site may deliver (b)(3) and Innovations services (same physical address). Validation would only occur once in this scenario. All (b)(3) sites not validated under an Innovations site, should be validated using the following validation strategies:

- Provider network/care coordination monthly monitoring; or
- Telehealth visits as outlined above; or
- Desk review using the HCBS Review Tool (see Appendix H)

Tier Two: DHHS Validation

The DHHS HCBS Internal Team will review a sample of LME/MCO validated provider self-assessments this process will begin this process upon receipt of the first quarterly reports from LME/MCOs.

Sampling

1. The sample size selected for review will be completed using Raosoft Sample Calculator http://www.raosoft.com/samplesize.html
2. DHHS will use RatStats to determine the sample. Sampling will be stratified, meaning it will include all service categories.

Desk Review: Utilizing the HCBS Review Tool, DHHS will request documentation used to initially validate (i.e., Care Coordination Tool: HCBS Quarterly Monitoring Tab, Provider Self-Assessments, My Individual Experience surveys and any policies or procedures that may have been used to support validation).

In the event that a discrepancy is found during DHHS validation review, DHHS will provide technical assistance and training to the LME/MCO or CAP-DA regarding its findings. All efforts will be documented on the HCBS Quarterly Reporting Tool. Trainings and Frequently Asked Questions will be maintained on the HCBS website and distributed to the HCBS Point of Contacts.

DHHS will also review My Individual Experience surveys that have reached the threshold within the time frame of January 1, 2018, through January 1, 2019, and extend the review period at each quarter until the end of validation on March 31, 2023. This will provide additional oversight to LME/MCO's and identify providers that may require remediation. Upon completion of validation and categorization of all settings, the NC HCBS STP will go out for public comment.

Summary of Validation and Remediation Process

The Covid-19 Public Health Emergency (PHE) delayed validation efforts in North Carolina from 2020 to 2022. On May 24, 2022, CMS updated the strategy for implementation of Home and community Based settings regulation. This updated guidance focused on aligning federal support with state compliance activities. In 2018, Provider Self- Assessments were completed and validation efforts initiated. NC DHHS, LME/MCO, and Local lead Agencies have collaborated over the past four years to ensure compliance with the HCBS Final Rule by March 17, 2023. NC DHHS validations strategies were implemented to ensure all settings would be Fully compliant/Fully integrated with the regulatory settings. To align with CMS expectation and updated guidance, the department released a Joint communication bulletin providing updated validation efforts and timelines to stakeholders.

March 8, 2022: HCBS validation and DHHS look-behind efforts relaunched.

April 15, 2022: Identification of all HCBS settings unwilling or unable to comply with HCBS settings requirements submitted to the DHHS HCBS Internal Team. Process begins for providing technical assistance to providers of non-compliant HCBS settings, beneficiary and family engagement, and transition planning for individuals receiving waiver services from sites unwilling or unable to comply with HCBS settings requirements.

May 1, 2022: Identification concludes of all non-compliant HCBS settings, HCBS settings unwilling or unable to comply with HCBS settings requirements, and individuals needing to transition to HCBS compliant settings.

June 8, 2022: Validation Quarterly Reporting tool (Final Submission) due to the DHHS HCBS Internal Team

June 15, 2022: Re-posting of Statewide Transition Plan for thirty-day public comment.

July 31, 2022: Re-submit Statewide Transition Plan for final approval to CMS.

December 31, 2022: Transitions conclude of individuals receiving waiver services from sites unwilling or unable to comply with HCBS settings requirements to HCBS compliant sites.
At this time, there are no sites providing services identified as unwilling or unable to comply. All NC HCBS providers have confirmed their commitment to continue providing Home and Community Based services in compliance with CMS Home and Community Based setting Final Rule.

Validation Reporting

NC DHHS implemented a validation process to ensure 100% compliance with HCBS Final Rule. The validation process confirms information submitted by providers on their provider self-assessment is accurate. During validation, provider sites are reviewed by using a Care Coordination onsite monitoring tool, desk review, or intense onsite review as verification that sites were meeting HCBS compliance. The Care Coordination monitoring tool is the preferred validation method, as the tools are used to monitor HCBS face to face. HCBS monitoring questions were added to the existing Care Coordination monitoring tool. This action allowed Care coordinator to monitor services and sites for HCBS compliance. If HCBS compliance issues are identified during the validation process the provider site will enter remediation. Reviewing entities will provide technical assistance during the remediation process to support the

provider site in reaching compliance with HCBS final rule. The reviewing entities submitted their final Quarterly Validation tool on June 8th, 2022. The HCBS internal team will conclude the final review of validated sites by October 31, 2022, to ensure all sites are Fully integrated/ Fully compliant with HCBS Final Setting Rule.

The HCBS Validation Reporting Tool template captures data for all sites requiring validation. LME/MCOs and CAP-DA submit reporting tools to the DHHS on a quarterly basis

- This provides adequate time for LME/MCO HCBS staff to review and provide remediation instruction to provider(s). Any outstanding remediation efforts not addressed within the quarterly report, are captured on the next quarterly report.
- As validation continues, a site is unable to be validated until all remediation efforts are completed. *(see Appendix G).*

Technical Assistance and Remediation Plan

NC DHHS validations efforts will conclude on or before October 31, 2022. The validation tool confirmed the date a site was validated, and which validation method was used (Care coordination tool-HCBS quarterly reporting tab, desk review or intense on site, Telehealth). Reviewing entities add validated information to the pre-populated validation, to ensure plan of action items are completed for sites deemed emerging or insufficient status. Once completed Provider Self-Assessments are deemed fully integrated/fully compliant in the database.

Technical assistance and remediation can occur during any stage of the validation process. A site must have successfully completed remediation in order to be considered validated with all aspects of the HCBS Final Rule.

The following is suggested criteria to identify sites that may require an on-site review:

a. A significant discrepancy in agency policies presented in provider self-assessment and Care Coordination Tool: Quarterly Monitoring Tab.
b. Concerns for potential heightened scrutiny that was noted as not meeting the threshold on the provider self-assessment.
c. Significant concern for isolation. Example: Documented use of a bus route; however, no bus route available at location.

**The on-site review would be completed by alternative LME/MCO staff member, not the care coordinator assigned to complete monitoring. (i.e. – Care coordinator supervisor or alternate care coordinator)*

If substantial remediation and/or technical assistance is identified during Validation, the LME/MCO may support the provider using the following methods:

a. Telephonic
b. Webinar
c. Onsite
d. Other – to include the HCBS Review Tool

Documentation used to remediate and bring the site into compliance should be maintained with validation materials. A site must have successfully completed remediation in order to be considered validated. Documentation used to bring the site into compliance might include and of the following:

- HCBS Provider Self-Assessment
- Care Coordination Monitoring Tools (see Appendix E)
- The provider's policies and procedures
- Beneficiaries' Individual Support Plans
- My Individual Experience Surveys
- Evidence of completed remediation

New providers are expected to be in full compliance at the time-of-service delivery for settings that must meet HCBS requirements would be routinely assessed during care coordination site visits. LME/MCOs and DHB CAP/DA staff remain the authority to allow services to initiate at the approved Medicaid site, meaning new providers may not provide services to individuals until they are marked in full HCBS compliance. NC DHHS HCBS validation will be completed December 31, 2022.

Tier 2 DHHS Validation

The DHHS HCBS Internal Team completed Tier 2 Validation (also referred to as look behind) reviews; from a sample of LME/MCO validated provider self-assessments. The HCBS Review Tool was utilized , DHHS requested documentation initially used to validate the sample sites. These documents included the Care Coordination Tool: HCBS Quarterly Monitoring Tab, Provider Self-Assessments, My Individual Experience surveys and any policies or procedures that may have been used to support validation. Discrepancies found during DHHS validation review were remediated through technical assistance and training to the LME/MCO or CAP-DA regarding its findings.

The HCBS Internal team has currently reviewed 143 sample sites, sites were stratified and included all service categories including Residential (Innovations and (b)(3), Day Support, Adult

Day Health, and Supported Employment. The DHHS HCBS Internal Team conducted desk reviews for all sites part of the selected sample. The DHHS HCBS Internal Team provided a summary of concluding findings and any remediation efforts to each LME/MCO. The LME/MCOs and Internal HCBS team Sites that entered remediation during the Tier 2 DHHS Validation continue to provide ongoing technical assistance throughout the process. Site in remediation will come into compliance with HCBS Final Rule by October 31, 2022. (see Appendix F)

Ongoing Monitoring

North Carolina's ongoing monitoring activities and functions will ensure continuous, long-term compliance to the HCBS settings regulation. Efforts will be a continuation of and incorporated in existing monitoring and performance improvement processes as outlined in this statewide transition plan. Additional details on all ongoing monitoring activities can be found below.

HCBS Setting(s) Monitoring- Post Transition Period

To ensure long-term compliance to HCBS settings regulation for all HCBS settings beyond the transition period, the NC DHHS will continue to receive HCBS Provider Self-Assessments for 100% of new sites related to Residential Supports, Day Supports, Adult Day Health, Coordinated Caregiving, and Supported Employment- Corporate settings utilizing the HCBS Provider Self-Assessment that NC DHHS created during the transition period. 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.

For new HCBS settings or providers, Providers will submit self-assessments, along with the evidence of compliance to include the provider's policies and procedures, to the assigned LME/MCO or DHB CAP/DA staff. It is important to note that providers who were not part of the transition period must be in full compliance prior to the provision of HCBS waiver services. DHB CAP/DA staff and the LME/MCOs will continue to require completion of an HCBS Provider Self-Assessment and ensure that services do not begin at that site until it is determined to be in full compliance with the HCBS settings regulation.

The DHHS, in collaboration with the LME/MCOs/CAP-DA staff, will 1) determine if individual provider assessments and provider policies and procedures are compliant with all aspects of the HCBS Final 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. Similar to the assessment process during the transition period, this will be accomplished using a standardized process with a standardized e-Review tool and companion document for evaluation of provider compliance. Additional evidence may be requested, or subsequent reviews conducted, as needed, to further assess compliance with all aspects of the HCBS settings rule.

Care Coordination Monitoring

Care Coordinator/Case Management monitoring will continue, ensuring that all Individuals are receiving services consistent with their person-centered plan and CMS requirements for HCBS settings. HCBS elements have been added into the existing Innovations Waiver Care Coordination Monitoring Tool. This will deliver a continuous monitoring and oversight system to ensure that providers are offering services and supports that are consistent with HCBS. It is important to note that LME/MCO Care Coordinators have face-to-face contact with individuals receiving Residential Supports at least one time per month and quarterly face-to-face contact with individuals receiving Day Supports and Supported Employment with monthly phone contact during months that do not have a face-to-face visit. Local Lead Agency Case Managers have quarterly face-to-face visits with individuals who are receiving Adult Day Health.

Any concerns noted with HCBS compliance will be reported to the Local Lead Agency/LME/MCO for follow up. Additionally, concerns may be submitted by email to HCBSTransPlan@dhhs.nc.gov or through the Customer Service and Advocacy Line at DMH/DD/SAS (http://www.ncdhhs.gov/assistance/mental-health-substance-abuse/advocacy-customer-service).

My Individual Experience Survey Ongoing Monitoring

Within the MIE survey process, threshold probing questions have been implemented to notify LME/MCO or Local Lead Agency and the DHHS HCBS Internal Team of disparities between consumer responses and provider assessment results. (For example, if a person selects a response of "no" for ~~5~~ 1 or more threshold questions, the threshold will be triggered, and notification will go to the appropriate parties to complete further review. Individuals are not to be made aware of trigger questions to protect the integrity of the assessment.

The LME/MCO or LLA is responsible for following up once notification is received that a threshold probing question(s) has been reached and will address using a Quality Monitoring Model, to manage provider support needs. Quality Monitoring may include, desk reviews, site reviews, and care coordinator site visits. Additionally, concerns may be submitted by email to HCBSTransPlan@dhhs.nc.gov to obtain technical assistance or remediation support.

Prior to April 1, 2019, all actions taken by the LME/MCO or DHB CAP-DA regarding My Individual Experience surveys and/or threshold notifications were documented on the HCBS

Threshold Questions Quarterly Report. These reports were submitted by the tenth of the month following the last month of the quarter. The DHHS HCBS Internal Team reviewed each report and determine if further follow up is required, in the form of desk reviews, agency conference calls and/or site reviews.

Beginning April 2019, DHHS monitored the MIE database for any MIE surveys that have responses that trigger the established threshold. During validation and ongoing monitoring, DHHS will coordinate with LME/MCOs and ~~LLA~~ DHB CAP-DA staff to ensure remediation with providers to support continued compliance with the HCBS final rule.

NC DHHS Quality Assurance Monitoring

On a quarterly basis, the DHHS HCBS Internal Team will complete Desk Reviews on a sample of HCBS Provider Self-Assessments the LME/MCO or CAP-DA staff assessed Full integration/Full compliant with all aspects of the HCBS settings regulation, similar to the process outlined under ***Tier Two: DHHS Validation.***

Sampling

- The sample size selected for review will be completed using Rao soft Sample Calculator http://www.raosoft.com/samplesize.html
- DHHS will use Rat Stats to determine the sample. Sampling will be stratified, meaning it will include all service categories.

Desk Review: Utilizing the HCBS Review Tool, the NC DHHS will request documentation submitted to the LME/MCO or CAP-DA staff at the time the HCBS Provider Self-Assessment was completed (i.e., any policies or procedures) and any additional evidence used to assess the setting Full/integration-Full/compliant. (see Appendix H)

In the event that a discrepancy is found during DHHS Quality Assurance monitoring, DHHS will provide technical assistance and training to the LME/MCO or CAP-DA regarding its findings. All efforts and findings will be documented on the HCBS Review Tool and written notification to the LME/MCOs or CAP-DA.

The DHHS will also continue to review My Individual Experience surveys that reach the threshold on a quarterly basis through reports submitted by the LME/MCOs and CAP-DA staff. This will provide additional oversight to LME/MCO's and CAP-DA and identify providers that may require remediation.

Ongoing Monitoring: Addressing Non-Compliance

Any issue of non-compliance with the home and community-based setting rules identified during scheduled or ongoing monitoring activities may generate a request for a Corrective Action Plan which must be implemented by the provider within forty-five days, with evidence of compliance required within an additional forty-five days, for a total of ninety days from the initial request for a Corrective Action Plan. The same applies to My Individual Experience Threshold Reports and DHHS' ongoing quality assurance monitoring activities.

Additional Efforts to Ensure Ongoing Compliance will include:

- Trainings and FAQs will be regularly updated and maintained on the NC DHHS HCBS webpage and distributed to all HCBS Point-of-Contacts
- Quarterly provision of HCBS Technical Assistance calls to LME/MCOs/LLAs/CAP-DA
- 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 ongoing compliance with standards;
- Identification or development of specific quality assurance/improvement measures that ensure compliance with the HCBS Final Rule;
- Continuation of a collaborative monitoring oversight process between the LME/MCOs/Local Lead Agencies, DHB and DMH.
- Consideration, 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 provision of technical assistance and education to individuals and their families, Provider Community and broader stakeholder community;
- DHHS will explore the use of National Core Indicators and other comparable data to support ongoing compliance and monitoring efforts,
- Continued partnership with the HCBS Stakeholder Committee; and
- HCBS characteristics will be integrated into quarterly reviews completed by CAP/DA and CAP/Choice, and the IMTs (Inter-Departmental Monitoring Teams) for the LME/MCOs.

Grievance Process:

A grievance is an expression of dissatisfaction by or on behalf of an individual about any matter. Per 42 C.F.R. § 438.400;N.C.G.S. § 108D-1 ; An individual receiving Home and Community Based Services or their legally responsible person has an opportunity to file a grievance. NC DHHS is required to ensure the LME-MCO's establish internal grievance procedures.

Individuals receiving HCBS through the Innovations Waiver may file grievances through their LME-MCO's listed below:

Alliance Health	5200 Paramount Parkway, Suite 200 Morrisville, NC 27560 919-651-8401 Please send your written complaint to Complaints@AllianceHealthPlan.org or to Alliance's Quality Management Department at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560. You may use the form on this page to submit your complaint. You can also file a complaint or grievance by telephone by calling the Alliance Access and Information Center 24/7 at (800) 510-9132. https://www.alliancehealthplan.org/members/information/rights/filing-a-grievance/
Eastpointe	514 East Main Street Beulaville, NC 28518 1-800-913-6109 File Grievance: Grievances/Complaints can be received by telephone, the electronic form https://app.smartsheet.com/b/form/3c64366423f544b98c25bae901a5f3ee), fax, mail, email or in person. If you need assistance completing the electronic Complaint/Grievance form or prefer to have the form mailed, you may contact the Eastpointe Grievance and Appeals Department at

	1-800-513-4002, Option #3. Eastpointe will assist you in completing forms to file a grievance/complaint. https://www.eastpointe.net/members-and-families/complaints-grievances-and-appeals/
Partners Behavioral Health Management	901 South New Hope Road Gastonia NC 28054 704-884-2501 File a grievance: Grievance/complaint can be received by telephone – Call **1-888-235-HOPE** (4673), Mail – Partners Health Management, C/o Grievance/Complaint, 901 South New Hope Road, Gastonia, NC 28054. Email Greivances@partnersbhm.org Online; Use our **feedback form,** Or in person Every employee at Partners is able to take your grievance/complaint. https://www.partnersbhm.org/grievances-complaints-and-appeals/
Sandhills Center	1120 Seven Lakes Drive West End, NC 27376 1-910-673-9111 File a Grievance: Grievance/complaints can be reported at the following link, https://www.sandhillscenter.org/for-consumers/grievance-form
Trillium Health Resources	201 W. First Street Greenville, NC 27858 866-998-2597

	File a grievance :**You can contact us by phone or in writing: By phone**, call Member and Recipient Services at 1-877-685-2415, 24 hours a day, 7 days a week. After business hours, you may leave a message, and we will contact you during the next business day. **You can write** us with your complaint to 201 West First Street, Greenville, NC 27858. You can also complete a form on the page below: **Complaint | Grievance** https://www.trilliumhealthresources.org/for-individuals-families/appeals-grievances
Vaya	File a Grievance: Member Services: 1-800-849-6127 Grievance Resolution and Incident Team: 828-225-2785, ext. 1600 24/7 Compliance Hotline: 1-866-916-4255 (allows for anonymous reporting). Vaya Health: Attn: Grievance Resolution and Incident Team 200 Ridgefield Court Asheville, NC 28806 ResolutionTeam@vayahealth.com vayahealth.ethicspoint.com (Allows for anonymous reporting)
Community Alternative Programs/Disabled Adults	A grievance is a complaint or dispute other than a NC Medicaid determination, expressing dissatisfaction with any aspect of the operations, activities or behavior of CAP/DA or its providers. you may contact NC Medicaid at 919-855-4343 to make a complaint orally or in writing. Medicaid.CAPDA@dhhs.nc.gov

Milestones

General Milestones	Start date	End date
Section 1. Identification		
To ensure compliance with CMS HCBS Final Rule (March 17, 2014), while improving personal outcomes for waiver recipients across North Carolina. **Outcome:** CMS Approval of Transitional Plan and Self-Assessment.	3/17/2014	3/16/2015 Completion: 1st submission: 3/12/15
Inventory of Settings and Day Services - CAP/DA (Community Alternatives Program - Disabled Adults) and CAP/C (Community Alternatives Program - Children): DHHS identifies comprehensive HCBS service provider type. **Outcome:** Consolidated and verified HCBS inventory.	11/25/2014	12/12/2014 Completion: 12/12/2014
Inventory of Settings and Day Services – Innovations: DHHS identifies comprehensive HCBS service provider type. **Outcome:** Consolidated and verified HCBS inventory.	11/25/2014	12/12/2014 Completion: 12/12/2014
Identified that (b)(3) services of Supported Employment, Day Supports, and Residential Supports to be included in HCBS transition plan: **Outcome:** Consolidated and verified HCBS inventory.	9/4/2015	9/4/2015 Completion: 9/4/2015
Full inventory of service providers of CAP/DA and Innovations waiver providers: Requested information from DHB CAP/DA staff and LME/MCOs on providers contracted with, to provide identified services and individuals authorized for services. **Outcome:** Consolidated and verified HCBS inventory.	7/20/2015	9/16/2015 Completion: 9/16/2015
Full inventory of service providers of (b)(3) providers of SE, DS, and RS: Requested information from LME/MCOs on providers contracted with to provide (b)(3) identified services and individuals authorized for services. **Outcome:** Consolidated and verified HCBS inventory.	10/12/2015	1/31/16 Completion:1/31/16
Finalize specific HCBS Informational Portal for Department Website: Links dedicated to implementation of HCBS Final Rule - Detail will include HCBS Final Rule of settings, review process,	11/25/2014	1/15/2015 Completion: 1/15/2015

General Milestones	Start date	End date
deadlines for compliance and availability of technical assistance (Ongoing Process). **Outcome:** Clear, streamlined, consistent information/communication for individuals, families, other valued stakeholders, LME/MCOs and DHHS Staff.		
Evaluate need for LME/MCO Contract amendment or Local Lead Agency (Case Management Entity) agreement revision specific to implementation of CMS HCBS Final Rule (March 17, 2014): Review of current LME/MCO/Local Lead Agency (Case Management Entity) contract/agreement to ensure global language regarding waiver compliance. **Outcome:** Contractual language required to ensure compliance with HCBS Final Rule between DHHS and LME/MCOs/Local Lead Agencies (Case Management Entities).	12/12/2014	12/19/2014 Completion: 12/19/2014
Section 2. Assessment		
DHHS developed the draft plan and the proposed Provider Self-Assessment with the HCBS Stakeholder Committee between October 2014 and January 2015. Outcome: Draft plan completed.	10/2014	1/9/2015 Completion: 1/9/15
DHHS has incorporated into the e-Review process a function that immediately denotes if a setting/site has the qualities of an institution. DHHS anticipates having this form added to their electronic process by the end of September 2015. Outcome: e-Review Heightened Scrutiny Tool	8/12/2015	9/30/2015 Completion: 9/30/15
Development of Provider Self-Assessment Tool: DHHS, with stakeholder input, develops self-assessment tool for providers to evaluate conformity to and compliance with the HCBS Final Rule. **Outcome:** Assessment vetted and endorsed by key stakeholders.	11/25/2014	3/2/2015 Completion: 3/1/2015
NCAC/Standards/Rules Review: Assess need for change to applicable rules, NC Administrative Code to ensure compliance with HCBS Final Rule. **Outcome:** Identify Administrative Code Changes per Legislative Process to ensure compliance with HCBS Final Rule. Regular	11/25/2014	7/1/2019 Completion:

General Milestones	Start date	End date
session of NCGS is held biennially convening in January after election –January. 14, 2015.		
Development and distribution of companion document: Develop a companion document to the self-assessment tool to offer guidance to providers. **Outcome:** Companion document completed.	1/28/2015	5/8/2015 Completion: 5/8/2015
LME/MCOs/Local Lead Agencies (Case Management Entities) complete self-assessment: Respective entities will complete self-assessment of policies, procedures, and practices. **Outcome:** Ensure Compliance with HCBS Final Rule.	2/1/2015	3/31/16 Completion 4/15/16
Test, Pilot and Modify Assessment Tool: Pilot self-administration of tool to ensure it captures elements and is universally understood by provider networks, LME/MCOs/Local Lead Agencies (Case Management Entities) and DHHS Staff. **Outcome:** Validated Tool.	3/16/2015	6/1/2015 Completion: 5/22/2015
Pilot providers complete self-assessment: Pilot providers will submit completed provider self-assessment to assigned LME/MCO/Local Lead Agency (Case Management Entity). **Outcome:** Pilot self-assessments competed.	5/11/2015	5/24/2015 Completion: 5/24/2015
Changes to tool based on pilot provider feedback: DHHS, with stakeholder input, makes changes to self-assessment tool for providers based on feedback from pilot sites. **Outcome:** Changes made to self-assessment based on pilot feedback.	5/24/2015	7/15/2015 Completion: 8/14/2015
All Providers Complete Self-Assessment: HCBS Providers will submit completed provider self-assessment to assigned LME/MCO/Local Lead Agency (Case Management Entity). **Outcome:** 100% Completion of Self-Assessments by CAP/DA, CAP/Choice, and Innovations waiver providers.	7/15/2015	9/15/2015 Completion: 9/15/2015
DHHS requested an extension to the six months within which assessments should be completed as we had published the timeframe of July 15, 2015, through September. 15, 2015, for the Statewide provider self-assessment process. **Outcome**: CMS granted this three-day extension in August. 25, 2015. Assessments completed.	7/15/2015	9/15/15 Completion: 9/15/2015

General Milestones	Start date	End date
(b)(3) providers complete self-assessment: (b)(3) providers will submit completed provider self-assessment to assigned LME/MCO **Outcome:** Completion of self-assessments by (b)(3) providers.	9/16/2015	10/15/2015 Completion:10/15/2015
Develop e-Review tool: Develop an e-Review tool for LME/MCO and DHB CAP/DA staff to review self-assessments. **Outcome:** e-Review tool developed.	5/4/2015	8/31/2015 Completion: 8/18/2015
Develop and distribute e-Review companion document: Develop an e-Review companion document to offer guidance to LME/MCO and DHB CAP/DA staff and to ensure consistency of reviews. **Outcome:** e-Review companion document completed.	5/15/2015	8/14/2015 Completion: 8/18/2015
Pilot self-assessments reviewed by LME/MCOs and DHB CAP/DA: LME/MCOs and DHB CAP/DA staff will review pilot self-assessments. **Outcome:** Provider self-assessments reviewed by LME/MCO and DHB CAP/DA.	7/16/2015	9/30/2015 Completion: 9/30/2015
Develop heightened scrutiny threshold document and process: Develop tool and process to identify sites that will require heightened scrutiny. **Outcome:** Heighted scrutiny document and process established.	7/21/2015	9/30/2015 Completion: 9/30/2015
Identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider, **Outcome:** List of settings that will be submitted to CMS.	9/30/2015	1/1/18 Completion: 1/1/18
Complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS. **Outcome:** Packet of information to be submitted to CMS.	9/30/2015	3/1/18 Completion: 3/1/18
Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment. **Outcome:** Statewide Transition Plan posted for public comment.	3/2/2018	6/1/18 Completion: No current sites are being submitted to CMS at this time that meet HS criteria.

General Milestones	Start date	End date
Submit STP with Heightened Scrutiny information to CMS for review **Outcome:** STP submitted to CMS.	6/1/18	6/30/18 Completion:
Provider Self-Assessment Data (pilot and Statewide) are Compiled and Analyzed by respective LME/MCOs/Local Lead Agencies (Case Management Entities). Completed Analysis will be provided by the respective entity to DHHS: LME/MCO Quality Management Teams or Local Lead Agency (Case Management Entity) designated staff compile the self-assessment data to determine those HCBS service providers who meet, do not meet, and those who could meet HCBS Final Rule with HCBS technical assistance. **Outcome:** Comprehensive report of results/findings and inventory reflecting compliance status.	10/1/2015	3/31/2016 Completion: 3/31/16
Develop tool/disseminate to submit analysis of self-assessment: Develop a tool to ensure consistency in the submission of information form the LME/MCOs and ~~DMA~~ DHB CAP/DA. **Outcome**: Analysis Tool.	9/28/2015	11/15/2015 Completion: 11/15/2015
LME/MCO/Local Lead Agency (Case Management Entity) Evaluation/Assessment Data, as compiled by the respective entity, will be provided to DHHS: Designated entities will complete self-assessment to ensure compliance with HCBS Final Rule. **Outcome:** Comprehensive report of results/findings and inventory reflecting compliance status.	8/1/2015	3/31/16 Completion 4/15/16
Vet need for an Individual "My Life" Experience Assessment Tool: Concurrent with validation process of representative sample, evaluate need for individual assessment to occur concurrently with the PCP process acknowledging the individual is "the expert" specific to their support, services, and personal outcomes. **Outcome:** Determination of Need for Individualized Self-Assessment.	10/1/2015	11/30/2015 Completion: 2/20/2015
My Individual Experience Tool: Development of the tool and process.	7/21/2015	8/25/2016 Completion: 8/25/2016

General Milestones	Start date	End date
Outcome: Individual Experience Assessment. Implemented 8/25/16.		
Establish a Monitoring Oversight Process to ensure integrity of the self-assessment process. LME/MCO Designated Departments, e.g., Care Coordination / Quality Management and DHHS / DHB / DMH/DD/SAS Accountability and Quality Management Sections and Local Lead Agencies (Case Management Entities) will continue utilizing the Care Coordination Tool and MIE Surveys for ongoing monitoring. **Outcome:** Validate Provider Self-Assessments.	12/31/17	12/31/2020 Completion:
Analysis of the self-assessment data from the LME/MCOs and DHB CAP/DA is due by March 31, 2016. **Outcome**:	1/1/2016	3/31/2016 Completion 3/31/16
Section 3. Remediation		
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 15, 2021. **Outcome**: All network providers in compliance with HCBS.	9/16/2016	6/30/19 Completion:
NCAC/Standards/Rules Remediation: Develop, adopt, and implement a comprehensive plan that will ensure compliance of State Regulatory Authority with the HCBS Final Rule. **Outcome:** Proposed language will be submitted to Rules Commission for consideration.	11/25/2014	6/30/18 Completion:
Rules Commission will consider proposed language or removal of rule. **Outcome:** Institute Rule changes to ensure compliance with HCBS Final Rule.	6/30/17	6/30/19 Completion:
Respond to notice from CMS on transition plan questions: Submitted written response to questions from CMS. **Outcome:** Correspondence with CMS	5/1/2015	5/6/2015 Completion: 5/6/2015
Update transition plan based on discussion with CMS: Received letter from CMS. Submitted written response. Had a discussion	8/12/2015	10/22/2015 Completion:

General Milestones	Start date	End date
with CMS on September 25, 2015. Will submit response as requested by CMS. **Outcome:** Updated Transition Plan submitted.		10/23/2015
Plan of Action Oversight: POAs, as submitted by Providers, will be vetted by LME/MCO Designated Departments, e.g., QM, Network and Local Lead Agency (Case Management Entity) designated staff to capture specific components/elements that will require tracking as part of the remediation process. Data summary will be provided to and reviewed and approved by DHHS. **Outcome:** Ensure Providers meet requirements of HCBS Final Rule.	10/1/2015	06/30/2021 Completion: 12/31/2022
Policy Development: HCBS will develop/revise Innovations policy to ensure compliance with HCBS Final Rule. **Outcome:** Approved Policy.	12/12/2014	03/16/2017 Completion: 11/1/16
Policy Development: DHHS will develop/revise CAP/DA policy to ensure compliance with HCBS Final Rule. **Outcome:** Approved Policy.	12/12/2014	3/16/2017 Completion 1/1/17
Policy Development: DHHS will develop/revise Innovations CAP/DA policies to ensure compliance with HCBS Final Rule specifically to include lockable entries for private rooms in facilities. **Outcome:** Approved Policy.	3/16/2017	07/01/2019 Completion date: 07/01/2019
Technical Assistance/Advisement to LME/MCOs/Local Lead Agencies and Provider Community: DHHS/- DHB - Clinical Policy Section and DMH/DD/SAS - I/DD Community Policy Section will provide technical assistance to any LME/MCO/Local Lead Agency or provider requesting support to ensure full compliance with the HCBS Final Rule. **Outcome:** Ensure providers are implementing necessary steps to obtain full compliance with the HCBS Final Rule.	12/19/2014	6/30/21 Completion: 12/31/2022
Continuation of Monitoring for Compliance with HCBS Final Rule: DHHS will incorporate HCBS requirements into policy/contracts as a mechanism to identify/determine any areas of non-compliance. Specifically, the following elements	3/16/2015	06/30/2021 Completion:

General Milestones	Start date	End date
will be included: responsible entity for monitoring; personnel required to complete monitoring functions; required training and process for monitoring staff; and protocol to manage concerns and other out of compliance issues. **Outcome:** Integrity of the Program; Provider Compliance with HCBS Final Rule; Established Audit Process.		04/30/2022
HCBS Technical Amendment - *CAP/DA Waiver*: Submission of Technical Amendment that includes elements from submitted March 17, 2015. Transition Plan Language will be incorporated into template once approved. **Outcome**: Waiver Amendment with encumbered language reflected from Transition Plan.	4/1/2015	Original End Date: 12/31/2016 Updated end date: Additional language around sleeping units will be added to the CAP-DA waiver on 7/1/19
HCBS Technical Amendment – *Innovations Waiver*: Submission of Technical Amendment that includes elements from submitted March 17, 2015, Transition Plan. Language will be incorporated into template once approved. **Outcome:** Waiver Amendment with encumbered language reflected from Transition Plan.	4/1/2015	10/31/2015 Completion: Amendment effective 11/1/16.
HCBS Final Rule Transition Plan Update: Upon completion of provider network assessment, DHHS summarizes findings and revises plan, as indicated, to ensure all components of compliance with HCBS Final Rule and appropriately reflects the DHHS's related mission and values. Remedial strategies will be included for providers not in compliance with HCBS Regulations. **Outcome:** Plan Update with Revised Remediation Strategy, as warranted.	10/1/2015	12/31/2016 Completion: 1/13/17
For providers needing compliance assistance, DHHS proposes the following strategies from July 1, 2015, through December 31, 2022, 30, 2020: Facilitate focus groups for providers that are both in and out of compliance with the HCBS Final Rule to encourage peer-to-peer support, problem solving process.	7/1/2015	6/30/2020 Completion: 12/31/2022

General Milestones	Start date	End date
Provide technical assistance through the development and scheduling of ongoing training regarding the Community Rule compliance, changes to the broader waiver and the overall effect on services. **Outcome:** Technical assistance provided as needed.		
Section 4. Outreach, Engagement and Public Notice/Comment		
Develop Initial Draft Plan: Gather Stakeholders, Division Leadership and LME/MCO/Local Lead Agency (Case Management Entity) input via multiple frameworks. Revisions to occur as warranted. Feedback will occur through face-to-face opportunities, fax, email, website submission and Listening Sessions. **Outcome:** Completion and submission of initial Transition Plan.	1/16/2014	2/25/2015 Completion: 3/1/2015
Public Notice/Comment Period - Following 30-day period, comments will be compiled and retained: Public Notice to occur through multiple venues. Transition Plan and proposed self-assessment per HCBS Final Rule will be shared. Such will occur, at a minimum, through DHHS website, LME/MCO/Local Lead Agency (Case Management Entity) collaborative, Provider Organizations, and valued Stakeholder Community. This will serve as interactive working opportunities between all vested partners. **Outcome:** Meet CMS HCBS Requirement of Public Notice.	1/21/2015	2/20/2015 Completion: 2/20/2015
Statewide Listening Sessions: DHHS Staff will share information regarding HCBS Final Rule and will obtain critical feedback from vested Stakeholders. **Outcome:** Feedback results in consensus and adoption of proposed transition plan.	2/1/2015	2/25/2015 Completion: 2/12/2015
Training for pilot sites on self-assessment: DHHS Staff will share information regarding HCBS Final Rule and will obtain critical feedback from vested Stakeholders. Provided face-to-face training on HCBS and self-assessment process. **Outcome:** Training completed.	5/22/2015	5/26/2015 Completion: 5/26/2015

General Milestones	Start date	End date
Statewide provider training: Provided face-to-face training on HCBS and self-assessment process. **Outcome:** Training completed.	7/7/2015	7/17/2015 Completion: 7/17/2015
Training and Education on HCBS Final Rule and Implementation of Transitional Plan and Self-Assessment: Collaborate with LME/MCOs/Local Lead Agencies (Case Management Entities) to develop, schedule, and facilitate training opportunities for individual recipients of services, families, provider network and valued stakeholders regarding ongoing waiver compliance, changes, and overall effect on individualized services. **Outcome:** Informed understanding of changes and impact for waiver recipients.	2/1/2015	Ongoing through process.
Dissemination of Revisions to Transition Plan Draft Initially Posted: Office of Communications will post any significant change to the plan following public comment. **Outcome:** Meet CMS HCBS Requirement of Public Notice.	3/2/2015	3/31/2015 Completion: 3/31/15
Presentations at conferences: Presentation at NC Provider Council, North Carolina Association for Rehabilitation Facilities, NC TIDE (the training organization for LME/MCOs), NC Council on Community Programs - Pinehurst. **Outcome:** Increase and improve public awareness and knowledge of HCBS.	3/1/2015	Ongoing through process as requested. Conferences are noted above in narrative.
Continued Input/Comment: DHHS with LME/MCOs/ Local Lead Agencies (Case Management Entities) will solicit feedback periodically to ensure ongoing waiver compliance, identify barriers, and areas of success and concern in preparation for submission of future waiver amendments and/or comprehensive plan. **Outcome:** Valued Feedback that will be incorporated into Comprehensive Waiver Plan as well as Department Policy and NCAC as warranted.	3/16/2015	Ongoing through process
Question and Answer Documents: Regular posing of questions received from LME/MCO staff, providers and other stakeholders and answered by DHHS. **Outcome:** Consistent and timely responses to questions.	5/8/2015	6/30/19

General Milestones	Start date	End date
		Completion: ongoing through validation process
Call with CMS September. 25, 2015. Plan text: The final plan, as submitted, is posted to the North Carolina DHHS website www.ncdhhs.gov/hcbs/index.html. Please note that this updated transition plan is being submitted at the request of CMS based on its call with the State September. 25, 2015. **Outcome**: Updated Transition Plan.	9/25/2015	9/25/2015 Completion: 9/25/15

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. 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 everyone. 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.

Appendix A

NC HCBS Standard Operating Procedures: HCBS Heightened Scrutiny Process

NC DHHS
HOME AND COMMUNITY BASED SERVICES (HCBS)
HEIGHTENED SCRUTINY REVIEW TOOL

Review Date: **Reviewer/s:**

Required Documentation from the Provider for Desk Review

1. Agency Policies and Procedures.

   Examples of policies and procedures expected to be submitted include but not limited to:

   - Participant rights and due process
   - Participant dignity and respect
   - Grievances and Complaints (reported to the provider and the LME-MCO/LLA)
   - Modifications to the HCBS Settings Rule for provider owned or controlled residential setting. (Any modification of the additional conditions for provider owned or controlled residential setting must be supported by a specific assessed need and justified in the person-centered plan.)
   - Staff training curriculums related to the policies and procedures listed above
   - Any additional policies and procedures referenced in the provider site's self-assessment and plan of action

2. Agency's provider site Self-Assessment and Plan of Action. The Agency's current self-assessment and plan of action for the site. This document will be accessed by DHHS staff from HCBS database.

3. Agency Heightened Scrutiny Threshold Assessment. This document will be pulled from HCBS database by DHHS staff.

4. Supporting Documentation to show:

    - Descriptions of community interaction and how close a setting is to community activities and public transportation.
    - Descriptions of how the facility is connected, or not, with any related institutional facility. Finances, shared administration, shared resources, shared staff, etc.
    - Evidence of how the general community considers the setting as part of the community
    - Evidence that Individuals are involved in the community outside of the setting

    Supporting documents that must be included:

    - Pictures and/or maps of the site, which may include nearby or related institutional or disability-specific sites. (This may be part of the HS assessment packet. If not, this should be included when submitting information for desk review.),
    - Service Notes - documentation supporting utilization of services as identified in the Person-Centered Plan for the individual to be interviewed (most recent month only),
    - Individual Support Plans (ISP) – individuals' current ISPs (provided by LME-MCO),
    - My Individual Experience Surveys – completed MIEs (preferably from database if available.) for individuals accessing waiver services.

      Sample Size:

        - All residential sites and site serving 10 or less – All individuals
        - Site serving 11 - 30 – 3 individuals
        - Site serving 31 - 60 – 4 individuals

- Site serving 61 - 100 – 5 individuals
- Site serving 101 or more – 5% up to a maximum of 15 individuals
  DHHS will ask the LME-MCO/DMA to randomly select, using the approved software the individuals for services notes, ISP, and MIE review.

Desk Review Assessment Tool

Services Provided at Site: Residential Supports ☐ Day Supports ☐

Supported Employment ☐ Adult Day Health ☐

Agency Name:			
Site Name:			
Provider NPI Number:	MHL Number or Certificate Date:		
Contact Name:	Contact email:		
Site Address:	City:	State:	Zip:
Are there policies/procedures that promote development and maintenance of community connections?	Yes ☐		No ☐
Are there any noted grievances and/or complaints against the site related to HCBS standards (access to the community, rights restrictions without process being followed, etc.)?	Yes ☐ If yes, were they appropriately addressed? Yes ☐ Please describe:		No ☐ No ☐
Provider Site Self-assessment: Assessment status HS reviewer questions or follow-up noted:	Full ☐ Emerging ☐ Insufficient ☐		

Provider Site HS Threshold Assessment: Sites identified to be on the same contiguous property? Additional sites under HS review? Sites identified to be on adjacent or nearby property? Additional sites under HS review? HS reviewer questions or follow-up noted:	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
HS reviewer questions or follow-up regarding description of how site is integrated in and supports full access to the greater community.	
Review of site maps and pictures: HS reviewer questions or follow-up noted:	Yes ☐ No ☐
Residential Setting Only	
Are there policies and procedures that support individuals inviting and having family and friends over to their home?	

Desk Review Follow-up for Onsite: * Reviewer may note any questions he/she would like follow-up on at the provider onsite review.	

Appendix B

HCBS Provider Self-Assessment Companion Guide

NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT COMPANION DOCUMENT

Compliance with Statewide Transition Plan Alignment with CMS HCB Setting Regulation Requirements
(42 CFR Sections 441.301 (c) (4) - (6); Section 441.302 and 441.530)

Companion Guide for Provider Self-Assessment

LME-MCO: ***Designated Home LME-MCO (for providers of NC Innovations Services only) OR*** **Local Lead Agency: (Case Management Entity)** ***Designated Lead Agency (for providers of CAP/DA and CAP Choice only).***

Provider Name (as appears on license or certificate, as applicable, or legal name): Denote name. **NPI#:** ***Reference NC Tracks***

MHL License/ Certificate Date (as applicable) ***official # is on license issued by DHSR***

- **Before completing self-assessment, indicate the intent to comply with all HCBS Setting Rule Requirements: Yes___ No ____** ***Answer only Yes or No***
  - **If Yes, continue.**
  - **If No, enter the number of individuals through Medicaid HCBS that will need to be transitioned:** ***Enter a number only if there is not intent to comply with HCBS Setting Rule Requirements.***
- **Self-Assessment must be completed for each site providing HCBS Service(s); submitting one for an organization will not be accepted.**

If you provide the following services, you need to complete a self-assessment...

Section I: Settings That Are Not Home and Community Based:

NOTE: Do NOT proceed past question 1 if any of the items are checked yes.

Waiver Type	*Service*	*Number of Surveys*
CAP/DA/CHOICE	*Adult Day Health*	*One per physical site*
NC Innovations	*Residential Supports*	*One per physical site*
NC Innovations	*Day Supports/Day Supports in Certified Adult Day Health*	*One per physical site*
NC Innovations	*Supported Employment*	*One per corporate site and a minimum of 10 assessments or 10%, whichever is greater.*

1. Is the facility one of the following? • *Nursing facility* • *Institution for Mental Diseases* • *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)* • *Hospital* **If any of these are checked yes, the facility cannot meet HCBS Criteria for community-based settings.**	***If there is a specific question, contact assigned LME-MCO Network Department or Local Lead Agency (Case Management Entity)*** ***Nursing Facility – a Medicaid Nursing Facility – (42 CFR 488.301)*** ***IMD Facility - defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services*** ***ICFIID – Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that— (a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and (b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability. Based on changes made in Rosa's Law in 2010, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) will now reflect nationwide changes and be referred to as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).*** ***Hospital - hospital is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;*** ***—42 C.F.R. § 441.301(c)(5) (about HCBS waivers); § 441.530(a)(2) (about Community First Choice programs); § 441.710(a)(2); 10A NCAC 27D .0301 Social Integration; 42 C.F.R. §435.1010: Sec 1919 SSA 42 U.S.C. 1395i-3; http://www.gpo.gov/fdsys/pkg/USCODE-***

	2008-title42/html/USCODE-2008-title42-chap7-subchapXVIII-partA-sec1395i-3.htm; Social Security Act Sec. 1861. [42 U.S.C. 1395x]; CFR 483.400 – 483.480; CFR 488.301
2. Is the facility in one of the following locations? • *a building that is also a publicly or privately operated facility that provides inpatient institutional treatment* • *a building on the grounds of, or immediately adjacent to, a public institution*	• **Examples include: State Developmental Centers, State Psychiatric Hospitals, Nursing Homes, etc.** • **Settings that are located on the same or contiguous property to an institution or are sharing space with an institution. Consideration must also be given to any applicable ordinances.**

• *a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.* **If any of these are checked yes, the setting is presumed to not meet HCBS Criteria for community based settings, and would require approval of the Secretary of the United States Department of Health and Human Services (HHS).**	• **Other examples include: Gated communities, settings that are isolated from the community at large, residential, or boarding schools that are disability specific, etc.** • **Any other setting that has the effect of isolating individuals receiving HCBS from the broader community.** • **The term public institution is defined in Medicaid regulations for the purposes of determining the availability of Federal Financial Participation (FFP). Section 435.1010, specifies that the term public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Medical institutions, intermediate care facilities, childcare institutions and publicly operated community residences are not included in the definition, nor does the term apply to universities, public libraries, or other similar settings.** • **If there are questions about a facility type/location, contact your assigned LME-MCO Department or Local Lead Agency (Case Management Entity) to seek clarification.** *—42 C.F.R. § 441.301(c)(5) (about HCBS waivers); § 441.530(a)(2) (about Community First Choice programs); § 441.710(a)(2)*

SPECIAL NOTE FOR SECTION II AND SECTION III:

All elements for each characteristic must be met for the response to be Yes. Evidence of support must be maintained, by the provider, in circumstances where element(s) of a characteristic is/are met. A plan of action/correction is required for any element(s) that is/are not met. This will ensure monitoring only occurs for the area(s) that is/are out of compliance. ***(Evidence is specific to the characteristic and is not typically policy/procedure or standard operating procedure unless otherwise noted, but may include any evidence of implementation.)***

Section II: General HCBS Criteria - Non-Italicized language (on the left side of the assessment*) reflects the actual characteristic and the italicized bulleted notations provide guidance to evaluate the characteristic. However, the italicized bulleted items are not all inclusive to each element of the characteristic.*

NOTE: This section MUST be completed, in entirety, if the following services are provided: Adult Day Health, Day Supports, Supported Employment and Residential Supports.

1. The setting is integrated in and supports full access to the greater community (work, live, recreate, and other services). There are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. • *Are transportation and other supports provided so that people can regularly access services similar to those used by the community at large?* • *Can people regularly interact directly with other members of the community who are not paid to do so?*	***Refer to CMS Steps to Compliance for HCBS Settings and Requirements in a 1915(c) Waiver and 1915 (i) SPA (State Plan Amendment) and Guidance on Settings that have the effect of isolating individuals receiving HCBS from the Broader Community located at:*** *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html* *Additional information can be found at the following links:* CAP/DA and Choice: http://www.ncdhhs.gov/dma/mp/3K2.pdf Innovations: http://www.ncdhhs.gov/dma/mp/8P.pdf ***Integration can be most readily defined as any situation/circumstance that does not meet the definition of isolated as defined by CMS.*** ***Some community integration examples are:***

	• ***The opportunity to get a job and work alongside people without disabilities.*** • ***Be part of the local community life, which must include what is of interest to the person, e.g. faith based activities, volunteer opportunities, local events, but must occur outside of the service setting.*** • ***Access to transportation resources (what is available to the general population) within a given community with recognition given to urban and rural barriers, e.g. urban – metropolis and rural – communities, village, hamlets, towns and cities.*** • ***Control their own money, possessions, and all other resources with appropriate help, which may include a financial coach, dual payee responsibility, etc.*** • ***Regularly interact with friends, family, co-workers that enhance the quality and security of a person's life. It represents "not to do for", but "with" people. If opportunities are always "scheduled" and are only "occasional" this does not meet the intent of "community-based".*** *—42 C.F.R. § 441.301(c)(4), (c)(4)(i) (about HCBS waivers); § 441.530(a)(1), (a)(1)(i) (about Community First Choice programs); § 441.710(a)(1), (a)(1)(i); 10A NCAC 27D .0301 Social Integration; § 168-2; § 168-3; § 168-8; § 168 A-6*
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for	• ***Choice of setting (includes any setting that is of interest to the person) is based on the preference(s) of the person and is the ultimate decision of the individual. Examples of evidence include, but are not limited to: providing information specific to the options presented, or places visited/employment considered, or individuals the person met during the planning process of choosing a place to***

residential settings, resources available for room and board. • *The setting is selected by people from among residential and day options that include generic settings.* • *Do people choose their rooms (if residence) or the area they work in, etc.?*	***live, work or engage during one's day, information contained in the person's individual plan, individual outcome measures, etc.*** • ***To ensure a person's preferences are being respected, were the choices presented in such a way that it was clearly understood by the person, e.g. conversation, picture, written, object format.*** • ***A setting that is chosen by an individual, if they are to receive HCBS services, must meet all the requirements of the rule (Final Rule March 2014).*** • ***Options provided align with the individual's available resources, e.g., SSI, VA, Special Assistance, Social Security, earned income, trusts, etc. (residential only).*** ***—42 C.F.R. § 441.301(c)(4)(ii) (about HCBS waivers); § 441.530(a)(1)(ii) (about Community First Choice programs); 42CFR § 441.301 (6) (2) (i)***
3. Ensures the rights of privacy, dignity and respect, and freedom from coercion and restraint. • *Do people have the space and opportunity to speak on the phone, open and read mail, and visit with others, privately?* • *Do people have a place and opportunity to be by themselves during the day?* • *Is **informed** consent obtained **prior to** implementation of intrusive medical or behavioral interventions?* • *For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?*	• ***There must always be the availability of space and time to ensure the individual can talk privately with family, friends and others of the persons choosing whether in person, over the phone or the internet (if access is available).*** • ***Even in shared situations, there must also be availability for a person to have "personal and alone time" as they define it during their day based on what is reasonable for that living setting and taking into account house/roommates. If an individual is unable to use words to communicate, information should be obtained from others that know the person the best to ensure they have opportunity for what is important to them.***

• *For people using psychotropic medications, is the use based on specific psychiatric diagnoses?* • *Do people receive the fewest psychotropic meds possible, at the lowest dosage possible?*	• ***10A NCAC 27D .0303 INFORMED CONSENT - Informed Consent by definition is given by a person who has a clear appreciation and understanding of the facts, implications, and future consequences of action, e.g., a reference reflective of all components of informed consent is the Consent Handbook, H. Rutherford Turnbull, and Douglas Biklen.*** • ***Plan for right restoration must be included in the person-centered plan at the time of restriction.*** • ***Behavioral Interventions/Physical Restraint: 10A NCAC 27E*** • ***Psychotropic Medication - Psychiatric diagnosis must be established prior to use of psychotropic medication to treat a mental health disorder. Other uses of psychotropic medication as prescribed by a health care practitioner for non-mental health disorders do not apply.*** *—42 C.F.R. § 441.301(c)(4)(iii) (about HCBS waivers); § 441.530(a)(1)(iii) (about Community First Choice programs); 10A NCAC 27G .0208 Client Services (a) (1); 10A NCAC 27G .0209 Medication Requirements (f) (1) (2); 10A NCAC 27d .0303 Informed Consent; 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions (c) (1) (2), (d) (1) (2) (3), (e) (1) (2) (3), (f) (1), (2) (A) (B) (C) (D), (3); §122C-62 (b) (1)*
4. Optimizes, but does not regiment, independent initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. • *Do people receive only the level of support needed to make their own decisions?*	• ***Individuals must be able to engage and make their daily decisions/choices, which includes, at a minimum, people they talk to, what they want to do during the day, where they spend their time, and with whom they have relationships. However, based on one's circumstances there are realistic considerations that must be made, i.e., people we support will experience realistic barriers such as defined work hours, immediate availability of people they***

• *Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?* • *Do people choose their daily activities, their schedules, and locations of the activities?*	***choose to help them; transportation schedules – bus may have stopped operating at 10:00 --- however ultimately the final outcome of the choices includes and is determined by the person. For example, if I am employed and only have 30 minutes for lunch and work in downtown Raleigh, I am not able to go Holly Springs for a lunch hour at my favorite restaurant on days that I am working. The consequence may be termination of my employment.*** • ***There must be flexibility for "last minute plans/changes" on what an individual may or may not want to do, e.g., again consideration must be given to financial resources, and individual choices e.g. - getting up at 3:00 a.m. desiring to walk at a favorite park 30 minutes from home may not be possible – but then what are the possible alternatives, e.g., a walking track around their home, a treadmill or Zumba DVD.*** • ***Adherence to 'typical rules' like paying rent, utilities, noise control, pets, etc. are expected, but there are not arbitrarily imposed rules such as who can visit, established curfews, restrictions on visits with family members or other people that the person chooses.*** • ***Support should only be available as needed and completely dependent upon the person's needs: e.g. I may need a ride to my appointment, but I can schedule it on my own; I can choose what I want to eat but, I need assistance to prepare it; I can access and utilize various technology, but need IT support when there is a problem.*** • ***A person's need for support should never reduce or eliminate options for the person, e.g. – it becomes an opportunity to "try a different way". Foster individual and creative solutions. A***

	person's need for support should never be used as a reason to "take away" or "restrict" options or to only provide those supports when the person makes the choices that coincide with the service schedule/routine. • ***Rights are not privileges. Individuals choose if they want to vote and for whom they will vote, etc. This may involve using a voter's guide, networking with the Board of Elections; voicing opinions – what are the opportunities for this, and do people understand how to share what they feel and with who when a specific outcome is desired; people choose religious services, and are not required to attend a staff's church, a family's "home church", or any church at all – but may choose to engage through tele-media, private mediation, or choose to not engage at all, etc.*** • ***Having the choices and freedoms does not mean people who receive HCBS should never have to do certain things at certain times. For example, if I have a job at Olive Garden, and am provided a work schedule , just as anyone else who works I must report to work at the scheduled times.*** • ***All adults should be afforded dignity of risk which balances individual choice and the responsibilities of support systems. Dignity of risk is reasonable movement to have the opportunity to fully experience the self-respect and self-esteem of being human.*** *—42 C.F.R. § 441.301(c)(4)(iv) (about HCBS waivers); § 441.530(a)(1)(iv) (about Community First Choice programs); 10A NCAC 27D .0301 Social Integration; 10A NCAC 27F .0105 Client's Personal Funds (a) (b) (c) (1) (2) (3) (4) (5) (6) (7) (8) (d) (1) (2) (3) (4); 10A NCAC 27D .0302 Client Self-Governance; 42 CFR § 441.301(D) Individuals are able to have visitors of their choosing at any time; §122C-62 (b) (7); §122C-62 (b) (8)*

5. Individuals are free and supported to control their own schedules and activities as well as have access to food at all times. • *Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being "told" what they are to do?* • *Do people receive support needed to make choices about the kinds of work and activities they prefer?* • *Is there evidence of personal preference assessments to identify the kinds of work and activities people want?* • *Do the individuals have meals at the times and places of their choosing?* • *Are snacks accessible and available at all times?*	• ***There must be clear evidence that the individual's schedule is not prescriptive (developed and imposed by support team without any involvement of the person), and is not identical to that of his/her housemates, but may have some similarities, e.g. (can they share/show their schedule; do they make/write their own schedule if one is needed, do they carry a personal copy/have it on their preferred technology device if this is important in their life, is it repeated from day to day with no changes noted?). Is there evidence that schedules are flexible and change as needed based on personal preferences? For example, if a person chooses to not go to the movies at the last minute this does not present a problem?*** • ***There must be evidence that a person is not required to get up, go to bed, take a bath, exercise at the same time every day, unless it is truly their choice. For minors more defined scheduling may be required, e.g., bedtimes, homework, tooth brushing three times a day could be examples – these are reasonable boundaries not restrictions.*** • ***There must be availability and noted use of preferred activities/ "things to do", e.g., television, board games, iPod, computer, etc. when a person chooses to do them yet lending consideration to the rights of others.*** • ***Evidence of free/supported control of an individuals' daily choice of preferred activities may include personal preference assessments or interest inventories to help identify what individuals like to do.***

	—42 C.F.R. § 441.301(c)(4)(iv) (about HCBS waivers); § 441.530(a)(1)(iv) (about Community First Choice programs); 10A NCAC 27G .0208 Client Services (a) (3) (c); 10S NCAC 27D .0301 Social Integration; § 168-8; §441.301 (vi) (C)
6. Facilitates choice regarding services, supports, and who provides them. • *Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.* • *Do people select the provider from a choice of providers?*	• ***Individuals are provided a choice regarding the services, provider and settings and the opportunity to tour, visit and understand the options available.*** • ***Choices of individuals may not align with selected vendors of provider agencies and must be carefully considered. For example, people using the same barber, pharmacy or for the convenience of being able to charge to a pre-established account. Individuals should be able to choose their retail and community service businesses.*** • ***The setting affords individuals the opportunity to update or change their preferences and can demonstrate this as an operating practice, e.g., educational support, house meetings, self-advocacy meetings.*** • ***The setting must ensure that individuals are supported to make decisions and exercise autonomy to the greatest possible degree.*** • ***The setting affords the individual with the opportunity to participate in activities that they prefer/like, but that are not work related.*** • ***The meaningful activities should occur within the person's community specific to their individual preferences while taking into account their needs.*** • ***Support staff must be able to demonstrate their understanding and knowledge of a person's capabilities, interests, likes as well as their dislikes.***

	• ***Individuals should be involved, if they desire, to choose their own support workers, e.g., involved in the interview process, meeting applicants when they visit potential work sites.*** • ***The provider must have a policy and demonstrate implementation of that policy which ensures that the individual has the needed supports to develop his/her plan that is specifically reflects their needs e.g., development of the plan is a joint responsibility of the person, Care Coordination (Innovations)/Case Management (CAP/DA, CAP Choice) and the Provider(s).*** • ***The provider must be able to demonstrate how the individual is best supported in making changes in their service array – there is joint responsibility between the provider and care coordination.*** ***—42 C.F.R. § 441.301(c) (4)(v) (about HCBS waivers); § 441.530(a)(1)(v) (about Community First Choice programs); § 441.710(a)(1)(v); 10A NCAC 27F .0103 (3); 10A NCAC 27D . 0302***
7. The setting is physically accessible to the individual. • *Have modifications been made to promote maximum access and use of physical environment for the person, if needed and requested?*	• ***The setting must ensure that there are no obstructions which include but are not limited to steps, doorway lips, narrow hallways or entrances that limits or prevents a person's ability to access all his or her living areas.*** • ***Reasonable modifications must be made that addresses an individual's needs specific to ensuring full access to the environment, e.g., grab bars, raised seats in the bathroom, shower chairs, ramps, reasonable height and location of tables/chairs, accessibility of washer and dryers, commensurate with an individual's needs, etc.*** • ***This requirement cannot be changed/modified as it meets ADA.***

	10A NCAC 27G .-0205; 10A NCAC 27G .0304 (a), (b) (1) (2) (3) (4) (5); ADA.gov
8. Individuals have privacy in their sleeping or living unit. • *Can the individual close and lock their bedroom door?* • *Is the furniture arranged as the individual prefers and does the arrangement assure privacy and comfort?*	• ***Individuals must be able to close and lock their personal living area (bedroom and bathroom) if they desire.*** • ***If they cannot close and lock their personal living area, it must be clearly addressed in the person-centered plan or assessment. For example, is it a health and safety issue that makes it a rights restriction? The restrictive intervention must also be reviewed/approved by a human rights committee before implementing with a plan to restore the right. Is it a training issue? Is it that the person does not have an interest after there has been opportunity for informed choice or is it that the person will never possess the ability based on individual circumstances?*** • ***A training plan must be developed to assist in the acquisition of that particular skill unless the person does not possess any ability or desire to do so and that must be noted in the plan, (e.g., a person that may be medically fragile and has no movement and requires total staff assistance).*** • ***The furniture must be adequate to meet the person's needs/preferences and must be arranged the way the person desires without posing an egress hazard.*** • ***The arrangement must ensure privacy and comfort for the person.*** • ***Staff and other housemates must always knock and receive permission prior to entering a person's bedroom, living area, or bathroom.*** *—42 C.F.R. § 441.301(c)(4)(vi)(B) (3) (about HCBS waivers); § 441.530(a)*

	(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B); 10A NCAC 27F .0102
9. The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has the same responsibilities and protections from eviction that tenants have under landlord/tenant law. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement or other form of written agreement in place for each HCBS participant. The document must provide protections that address eviction processes and appeals comparable to those provided under landlord/tenant law. • *Do people have the same responsibilities that other tenants have under landlord/tenant laws?* • *Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?*	• ***HCBS Services cannot occur in settings that restrict an individual's choices as well as any aspect of their daily life. Individuals have the same rights and responsibilities under state law as any tenant. This includes no eviction/discharge without cause or proper notice. Health and safety remain paramount. This includes eviction/discharge without proper and justified notice. Individuals must know their rights and responsibilities regarding housing and when they could be required to move and this information included in their ISP or assessment.*** • ***Is there a lease, residency agreement, memorandum of agreement or other agreed upon form of documentation between the individual and the landlord?*** *—42 C.F.R. § 441.301(c)(4)(vi)(A) (about HCBS waivers); § 441.530(a)(1)(vi)(A) (about Community First Choice programs); § 441.710(a)(1)(vi)(A) §168-9; 10A NCAC 27 G. 0201; add d/c NCGS.*
10. Units have entrance doors lockable by the individual with only appropriate staff having keys to doors. • *Each person living in the unit has a key or keys for that unit.*	• ***Individuals have access to the entrance, bedroom and bathing areas through whatever key system is utilized by the facility if the individual possesses the required skill set to do so safely and does not place themselves at risk of injury. Training in identified areas of need must be carefully assessed.***

Is there evidence that efforts are being made to teach use of a key to anyone who does not understand how to do this?	• ***Support staff does not indiscriminately use master keys to gain access without appropriately knocking and receiving permission prior to entering. In the event of a health and safety concern or the person is at risk this would not be expected. Support staff should only gain access without permission in the event of a health and safety concern or the person is considered to be at risk.*** • ***The plan and/or assessment reflects that the person has the ability to gain access/use key system to their home or a training plan is developed to assist in the acquisition of that particular skill unless the person does not possess any ability or desire to do so and that must be noted in the plan. This is a joint collaborative between, the person, their Care Coordinator, and their provider.*** ***—42 C.F.R. § 441.301(c)(4)(vi)(B) (1) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B);***
11. Individuals sharing units have a choice of roommates in the setting. • *Do people choose their roommates?*	• ***The home has a process to assist the individual to choose a roommate/housemate regardless of whether the person does or does not use words to share their opinions/desires.*** • ***Married couples are afforded a choice of sharing a room.*** • ***The home has a process for the individual to request a roommate change should they desire one, but this not guaranteed a change will occur based on what may be available – but that the person is afforded the opportunity to explore.*** • ***The individual expresses that they are satisfied with their roommate through contacts with their Care Coordinator, to their support staff and during their person-centered planning (ISP) meeting.***

	• ***A consideration may be for homes to have a process for existing individuals to be a part of screening/choosing for persons interested in moving into their home.*** • ***Married couples are afforded a choice of sharing a room.*** ***—42 C.F.R. § 441.301(c)(4)(vi)(B) (2) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1); (vi)(B)***
12. Individuals are free to furnish and decorate sleeping and living units. • *Does each person pick the decorative items in their own private bedroom?* • *Do people living in the same unit participate in the choices of decorative items in the shared living areas of the unit?*	• ***Individuals are supported and encouraged to choose items of their preference for their specific room/living area, e.g., this would include the person's individual bedroom and other shared common areas of the home, however reasonable consideration must be given to all persons residing within the home in making these decisions/choices.*** • ***This is not a choice of one or two items, but an opportunity to visit stores of choice, on-line shopping, seeking assistance from people of their choice to accompany or assist them with shopping.*** ***Consideration must be given to an individual's financial resources.*** ***—42 C.F.R. § 441.301(c)(4)(vi)(B) (3) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B); § 168-8; 10 A NCAC 27F.0102***
13. Individuals are free to have visitors of their choosing at any time. • *Are people supported in having visitors of their own choosing and to visit others frequently?*	• ***Individuals are supported to have visitors of their choosing in their home , e.g., is the person assisted to make a phone call, coordinate time that works for both the visitor/friend and the individual;*** • ***Help the individual understand what are acceptable social practices;*** • ***Visitors cannot infringe on the rights/space of an individual's house or roommates.***

• *Are people satisfied with the amount of contact they have with their friends?*	*—42 C.F.R. § 441.301(c)(4)(vi)(D) (about HCBS waivers); § 441.530(a)(1)(vi)(D) (about Community First Choice programs); § 441.710(a)(1)(vi)(D); 10A NCAC 27D .0301; 10A NCAC 26B .0108; APSM 45-1 10A NCAC 26B .0108 (a) (b) (1) (2) (3) (4) (5); 122C-62 (b) (1)*
14. Any modification of the additional conditions for provider owned or controlled residential setting must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan. 1. *Identify a specific and individualized assessed need.* 2. *Document the positive interventions and supports used prior to any modifications to the person-centered service plan.* 3. *Document less intrusive methods of meeting the need that have been tried but did not work.* 4. *Include a clear description of the condition that is directly proportionate to the specific assessed need.* 5. *Include regular collection and review of data to measure the*	***If any modifications are needed for any of the characteristics, assist the person to contact their responsible Care Coordinator/Case Manager to schedule a meeting. The meeting will be for the sole purpose to discuss, address and modify the person's individual plan.*** *10A NCAC 27G .0206 Client Records; APSM 45-2 Chapter 4-10; Review and Annual Rewrite of Person-Centered Plan; APSM 45-2 Chapter 4-6 The Crisis Plan as A Required Component Of The Person Centered Plan*

ongoing effectiveness of the modification. 6. *Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.* 7. *Include the informed consent of the individual.* 8. *Include an assurance that interventions and supports will cause no harm to the individual.*	

Appendix C

Service	Yes- Full Integration/Full Compliance	No- Full Integration/Full Compliance (Sites in Remediation)	Total
Adult Day Health	23	5	28
(b)(3) Supported Employment	219	157	376
(b)(3) DI Services	7	11	18
Day Support	328	98	426
Residential Supports	4029	1458	5487
Supported Employment	465	484	949
Total	5071	2213	7284

Appendix D

Validation Method Chart

Service Type	Care Coordination (On-site)	Desk Review	Intense On-site Review	Telehealth	My Individual Experience Surveys
Residential (Innovations & (b)(3))	X	X	X	X	X
Day Support & Adult Day Health	X	X	X	X	X
Supported Employment (Innovations & (b)(3))	X	X			X
Supported Employment- Corporate Site	Only if an individual is working at corporate site agency.	X	X	X	

Appendix E

Care Coordination HCBS Criteria Tool

Care Coordinator:
Site Name:
Site Address:

HCBS MONITORING CHECK SHEET				
	Type of Monitoring (In-Person, Telehealth, Telephonic):			
	If an In-Person or Telehealth Visit was not completed, indicate the reason why not:			
PROVIDER: **INDIVIDUAL:**			**DATE:**	
	Minimum responsibility for general monitoring is to be alert for these items, ask individual about items, discuss with provider QP as applicable to confirm that all requirements		**Check/Comments**	

	are met, follow-up further as indicated.			
	Does the individual live/receive services in the same areas of setting as an individual not receiving Medicaid HCBS (Individual receiving waiver services is not separated or unable to interact with other individuals in the setting.)			
	Does the setting fit in with surrounding neighborhood? (no permanent	Residential Only		

	parking spaces; no signs in yard indicating the home is a group home; another group home or day program is not located on the same property or immediately adjacent.)			
	Is the home in location that supports full access to the greater community or is transportation available to access the community?	Residential Only		
	Observation indicates that staff communicate with individuals			

	in a respectful manner with individuals in the setting while providing assistance and during the regular daily activities.			
	Observation/report indicates individuals are not required to sit at an assigned seat in the dining area and may choose with whom to eat; individuals are not required to wear bibs, clothing protectors, or use disposable cutlery, plates and cups (in their home).			

	There is no evidence/report that visitors are restricted to specified visiting hours or restricted to a specific 'visitors' area'.			
	Observation/report that individual has privacy in his/her living space.	Residential Only		
	Do staff or other residents always knock and receive permission prior to entering an individual's living space?	Residential Only		
	Observation that the individual has a key to the home and his/her room.	Residential Only		

	Does staff only use a key to enter a living area or privacy space under limited circumstances agreed upon with the individual?	Residential Only		
	Observation at site indicates that schedules of individuals for physical therapy (PT), occupational therapy (OT), medications, restricted diet, etc., are not posted in a general area for all to view.			
	Observation/report that furniture arrange as	Residential Only		

	individual prefers in his/her living space and they are allowed to decorate?			
	Evidence/Observations of personal preference assessments to identify the kinds of work and activities individual wants to participate in?			
	Observation indicates the individual is working in an integrated setting.	Supported Employment Only		
	Observation indicates that the individual has unrestricted access in the setting. (there			

	are no gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting (excluding staff office/staff living quarters; individual has unscheduled access to food, phone, internet, etc.)			
	Observation/report indicates that tables and chairs are at a convenient height and location so that individuals can access and use			

	the furniture; that appliances are accessible to individuals (e.g., the microwave at the day program or the home washer/dryer are front loading for individuals in wheelchairs).			
	Does the individual have telephone or other technology in their own room or in a location that has space around it to ensure privacy?	Residential Only		

Appendix F

Tier 2 DHHS Validation

Service Type	Sites fully Integrated Compliant	Sites in remediation
Residential Innovations & (b)(3)	**80**	**33**
Day Support & Adult Day Health	**10**	**1**

Supported Employment -	**20**	**0**
Total	**110**	**34**

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Appendix G

HCBS Validation Tool (Sample)

Site Name	Address	City	State	Zip	Service type	Facility Type	Facility Other	Validation Method	Month/ Year site was validation	Date new plan of Action Assigned to provider	Date New plan of action completed/verified	Actions	Transfer to the Following LME-MCO (Receiving LME-MCO Must be aware)

Enter the information requested in the yellow highlighted cells in Column B.
Information entered here will automatically be entered in all applicable worksheets in this workbook.

Workbook Set-up Information	
LME/MCO or CAP/DA:	
PROVIDER NAME:	
FACILITY NAME (Service Site):	
LOCATION (Address):	
NPI #:	
PROVIDER #:	

MHL #:	
NAME OF REVIEWER(S):	
BEGIN REVIEW DATE:	
END REVIEW DATE:	
TYPE OF REVIEW:	

	[Name of LME/MCO]												
PROVIDER NAME:													
FACILITY NAME:													
NAME OF REVIEWER(S):													
REVIEW DATE(S):													
TYPE OF REVIEW:		**ITEM SCORE**					**SECTION SCORE**					**COMMENTS**	
REVIEW ITEM:	**FINDING**	**# MET**	**% MET**	**# NOT MET**	**% NOT MET**	**# N/A**	**# MET**	**# NOT MET**	**# N/A**	**% MET**	**SECTION SCORE**	**DHHS Comments**	

[Requires 100% across the section]	**INTEGRATION**										
Are transportation and other supports provided so people can regularly access public amenities and other transportation resources similar to those used by the community at large?	**Met**	1	100%	0	0%	0	4	0	0	100%	**MET THRESHOLD**
Can people regularly interact directly with other members of the community who are not paid to do so?	**Met**	1	100%	0	0%	0					
Efforts to obtain employment opportunities are pursued that will allow the individual to work alongside those of all abilities.	**Met**	1	100%	0	0%	0					
Setting is in the community among other private residences, and/or retail businesses, is in an appropriate location based on function.	**Met**	1	100%	0	0%	0					
[Requires 100% across the section]	**CHOICE OF SETTING**										
The setting is selected by people from among residential and day	**Met**	1	100%	0	0%	0	2	0	0	100%	**MET THRESHOLD**

options that include generic settings												
Do people choose their rooms (if residence) or the area they work in, etc.?	**Met**	1	100%	0	0%	0						
[Requires 100% across the section]	**HUMAN RIGHTS**											
Settings ensure protection of the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	**Met**	1	100%	0	0%	0						
Do people have the space and opportunity to speak on the phone, use technology, open, and read mail, and visit with others, privately and, where appropriate, overnight? (Residential Only)	**Met**	1	100%	0	0%	0	7	0	1	100%	**MET THRESHOLD**	
Do people have a place and opportunity to be by themselves during the day? (excludes Supported Employment)	**Met**	1	100%	0	0%	0						
Is informed consent obtained prior to implementation of intrusive medical or behavioral interventions?	**Met**	1	100%	0	0%	0						

For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?	**Met**	1	100%	0	0%	0						
For people using psychotropic medications, have all the less-restrictive interventions been considered and determined to be inappropriate?	**Met**	1	100%	0	0%	0						
Do people receive the fewest psychotropic medications possible, at the lowest dosage possible?	**Met**	1	100%	0	0%	0						
Do people receive supports and education in understanding one's own health and opportunities to change and improve?	**N/A**	0	0%	0	0%	1						
[Requires 100% across the section]	**INDEPENDENCE & AUTONOMY**											

Do people receive only the level of support needed to make their own decisions?	**Met**	1	100%	0	0%	0						
Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?	**Met**	1	100%	0	0%	0	2	0	0	100%	**MET THRESHOLD**	
[Requires 100% across the section]	**SCHEDULES & ACTIVITIES**											
Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being "told" what they are to do?	**Met**	1	100%	0	0%	0						
Do people receive support needed to make choices about the kinds of work and activities they prefer?	**Met**	1	100%	0	0%	0	5	0	0	100%	**MET THRESHOLD**	
Is there evidence of conversations and/or assessments to help identify personal preference for the kind of	**Met**	1	100%	0	0%	0						

work and activities people want?												
Do the individuals have meals at the times and places of their choosing?	**Met**	1	100%	0	0%	0						
Are snacks accessible and available at all times? (Excludes Supported Employment)	**Met**	1	100%	0	0%	0						
[Requires 100% across the section]	**SERVICE DECISIONS**											
Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, retail stores). Do people shop, attend religious services, scheduled appointments, have lunch with family and friends, etc., in the community, as the choose?	**Met**	1	100%	0	0%	0	2	0	1	100%	**MET THRESHOLD**	
Do people select the provider from a choice of providers?	**Met**	1	100%	0	0%	0						

Are risks identified and methods for minimizing them addressed?	**N/A**	0	0%	0	0%	1					