TRANSITION PLAN

For Complying with the CMS Home- and Community-Based Services Medicaid Rule

FOR THE STATE OF NORTH CAROLINA

The CMS-approved North Carolina transition plan can be found at:
https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule/hcbs-plan-submission

North Carolina did not request a Corrective Action Plan (CAP).

SITE-SPECIFIC ASSESSMENTS

The Centers for Medicare & Medicaid Services (CMS) required states to conduct validated, site-specific assessments of all provider-owned or controlled settings.

Types of Settings/ Residents and Funding Authorities	North Carolina conducted an internal review of its state statutes and regulations governing Medicaid HCBS waiver services and assessed that the HCBS Settings Rule applies to three 1915(c) waivers and select services offered under the 1915(b)(3) benefit Services under the North Carolina waivers are provided in a variety of settings. Community Alternatives Program for Children (CAP/C) waiver settings: • Recipient home • Foster home • Skilled Nursing Facility (SNF) Community Alternatives Program for Disabled Adults (CAP/DA) waiver settings: • Recipient home • Adult Day Health facilities • SNF Innovations waiver settings: • Recipient home • Group homes • Licensed and unlicensed Alternative Family Living arrangements • Adult Day Health/Adult Day Care • Day Support facilities • Institutional Respite in an Intermediate Care Facility
Compliant/Non-Compliant	Fully compliant settings: • Adult Day Health: 27 • Day Support: 228

	• (b) (3) DI Services: 17 • Licensed 5600(b) Residential: 11 • Licensed 5600(c) Residential: 535 • Licensed 5600(f) Residential: 129 • Unlicensed Alternative Family living home: 771 • Supported Employment (1915i): 326 • Supported Employment: (b)(3): 137 Total number of fully compliant settings: 2181 Do not comply, but could with modifications: • Adult Day Health: 0 • Day Support: 0 • (b)(3) DI Services: 0 • Licensed 5600(b) Residential: 0 • Licensed 5600(c) Residential: 0 • Licensed 5600(f) Residential: 0 • Unlicensed Alternative Family living home: 0 • Supported Employment (1915i): 0 • Supported Employment: (b)(3): 0 Total number of settings that do not comply, but could with modifications: 0 Cannot Comply or are Unwilling to Comply: • Adult Day Health: 24 • Day Support: 77 • (b)(3) DI Services: 25 • Licensed 5600(b) Residential: 22 • Licensed 5600(c) Residential: 109 • Licensed 5600(f) Residential: 109 • Unlicensed Alternative Family living home: 1180 • Supported Employment (1915i): 287 • Supported Employment: (b)(3): 127 Total number of settings that are unable or unwilling to try: 1960 Total number of settings submitted application for Heightened Scrutiny to CMS: 0 Total number of settings evaluated via the provider self-assessment: 4141
Reasons for Non-Compliance	Specific reasons for non-compliance were not listed.
Transition plans	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 be impacted by the implementation of the transition plan. 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 included identification of the type of setting and service provided, evidence supporting compliance with HCBS standards, and proposed remediation for standards that are out of compliance. The DHHS HCBS Internal Staff in collaboration with Local Management Entities/Management Care Organizations (LME/MCOs) and other staff assured that at least one validation strategy was used to validate provider self-assessments. The term validate was used to confirm the accuracy of provider self-assessments, in conjunction with the lived experience of the beneficiary, met compliance with all aspects of the HCBS Final Rule by March 17, 2023. Validation strategies include: • Face to face Care Coordination • Desk Review • Intense On-site Review • Telehealth Visit For settings in partial compliance or not in compliance, remediation plans are created, and technical assistance is provided. For settings presumed by CMS and/or the State not to comply with the HCBS Settings Rule, the state will request heightened scrutiny screenings for settings. An onsite visit is conducted for settings screened in to determine if there is sufficient evidence to present to CMS that the setting is in fact community based. For settings found out of compliance and unwilling to comply, the State will assist in the relocation of participants. Ongoing monitoring and quality assurance activities will be conducted moving forward.

SETTINGS PRESUMED INSTITUTIONAL

CMS presumes some settings have qualities that are institutional or isolating in nature. These settings must go through a heightened scrutiny review by CMS.

CMS presumes the following types of settings have institutional or isolating qualities:

- *Category 1: Located in a hospital, nursing facility, or other institutional setting.*
- *Category 2: Located adjacent to a public hospital, nursing facility, or other institutional setting.*
- *Category 3: Have the effect of isolating people from the broader community.*

% Presumed Institutional (No. of Residents Affected)	30 residents were affected and required to relocate.
Type of Setting/Residents	There were two Day Supports programs, one on the grounds of an ICF IID and the other on a disability-specific farm. One Adult Day Health Center was on the grounds of a hospital. One Supported Employment site obtained fresh vegetables from the grounds of an ICF IID. The final site had a three-bed group home on the same grounds as a day program. These settings made the decision to close or transition individuals into a setting in compliance with HCBS settings rule. • Day program on the grounds of a farm: # of individuals transitioned: 8 • Supported employment on the grounds of a farm: # of individuals transitioned: 7 • Supported employment site that obtains fresh vegetables from the grounds of an ICF IID: # of individuals transitioned: 3 • Adult day health program located on ground of a private inpatient institution: N/A • Day program on the campus of a private ICF-IID: # of individuals transitioned: 12
Reason for Presumption	The location of the setting made the settings above presumed institutional.
Heightened Scrutiny Process	If the provider self-assessment triggered a Heighted scrutiny review, the DHHS HCBS Internal Team engaged a process through the development of threshold assessment to determine if heightened scrutiny was warranted. Staff shared the form with the provider agency if heightened scrutiny applied. The provider had 10 (ten) business days to complete and return the threshold assessment. Follow-up occurred based on the review of the form within five business days. If the site did not warrant heightened scrutiny, the assessment process continued as with any other provider. If the site was found to warrant heightened scrutiny, then a desk review was completed within five business days of the receipt of all documents submitted. If the DHHS HCBS Internal Team determined the site was able to overcome the institutional presumption, the site was submitted to CMS's heightened scrutiny process including a request for public comment on the setting. If determination was made that a site could not overcome institutional presumption, the HCBS internal team

	worked with staff, individuals, families, and providers to transition individuals into sites that met full compliance with HCBS rule.
NON-COMPLIANCE COMMUNICATION	
% Cannot/Will Not Comply (No. of Residents Affected)	As of May 31, 2022, the department confirmed there were no individuals receiving HCBS services in sites unable or unwilling to comply. All sites providing HCBS services indicated their intent to be compliant with HCBS Final Settings Rule.
Type of Setting/Residents	Not applicable.
Reason for Determination	Not applicable.
Communication Strategy	For providers identified within the transition period, who are deemed unable or unwilling to comply with HCBS Settings Rule, DHHS required a plan of remediation, with a 30-day deadline from date of issuance to fully comply. If compliance did not occur within thirty days, the provider was prohibited from providing the HCBS service in question at that site until such time full compliance with the HCBS Final Rule as reached. The case management entity, in collaboration with the DHHS contractor determined if a provider was terminated from network for failure to fulfill HCBS criteria.
Assistance to Residents?	In the event the provider was unable to complete the remediation plan. The provider was obligated to: • Create and implement a plan, detailing how individuals 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. • Work with the LME-MCO or other staff to ensure the seamless transition of individuals supported to an appropriate provider so there is no service interruption. If a provider was unable to come into full compliance, the management entities facilitated the transition by ensuring: • All beneficiaries received a minimum sixty-day notice before being relocated to an HCBS compliant site (unless was an imminent need to expedite the transition process). More notice was granted in instances where other housing options were secured (specific to the service of residential supports only), • 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, to ensure the individual and family have been fully informed of any applicable due process rights, • A comprehensive listing of providers to consider for continuation of services from staff. The assigned staff scheduled 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. During the face-to-face visits, the assigned LME/MCO or Community Alternatives Program for Disabled Adults (CAP/DA) staff informed the individuals of any applicable due process rights. The LME-MCO and CAP/DA submitted approved plans of remediation and or transitional plans to the DHHS Internal Team for review, monitoring, and tracking.
ONGOING MONITORING	
Monitoring Procedures	The NC DHHS will continue to review HCBS Provider Self-Assessments for 100% compliance of new sites through utilizing the HCBS Provider Self-Assessment that NC DHHS created during the transition period. Care Coordinator/Case Management Ongoing Monitoring: Care Coordinator/Case Management will continue ensuring that all individuals are receiving services consistent with their person-centered plan and CMS requirements for HCBS settings. • 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 services in their private home; • Day Supports and Supported Employment with monthly phone contact during months that do not have a face-to-face visit. • Local Case Management Entities Case Managers have quarterly face-to-face visits with individuals who are receiving Adult Day Health. My Individual Experience (MIE) Survey Ongoing Monitoring: • DHHS will continue ongoing monitoring of the MIE database for any MIE surveys that have responses that trigger the established threshold. DHHS will coordinate with LME/MCOs

	and CAP/DA staff to ensure remediation with providers to support continued compliance with the HCBS Settings Rule. • The LME/MCO or the LLA will remain responsible for following up once notification is received that a threshold probing question(s) has been reached and will address concerns using a Quality Monitoring Model, to manage provider support needs. Quality Monitoring may include, desk reviews, site reviews, and care coordinator site visits. 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. Additional efforts to ensure ongoing compliance 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 or 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 or CAP/DA, and DHHS, • 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.
Quality Assurance Measures	See above for information about quality assurance/improvement measures and quality assurance monitoring activities.