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 Medical Assistance

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

January 2017

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 worked with stakeholders to draft a transition plan to come in compliance with this 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 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 2018, initial and ongoing compliance with the HCBS Final Rule. The DHHS will work in partnership 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, the State 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.

HCBS Final Rule Setting Requirements

- 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;
- They also facilitate individual choice regarding services and supports, and who provides these.

Provider Owned or Controlled Residential Settings – Additional Requirements

- Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;
- Provide privacy in sleeping or living unit;

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

- 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 the State's plan is to ensure that individuals receive Medicaid HCBS in settings that are fully integrated and support access to the greater community.

Home and Community Based Services in North Carolina

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 a service. Institutional Respite may also be provided in a Skilled Nursing Facility (SNF).
- Under the Community Alternatives Program for Disabled Adults (CAP/DA) and CAP/Choice waiver, individuals may receive services at home where they reside with their family or in Adult Day Health facilities (certified under 131-D). Institutional Respite may also be provided in a SNF.
- Under the Innovations waiver, individuals may receive services in their home or in the home of their family, in licensed (5600(b) and (c) group homes and licensed Alternative Family Living arrangements (5600(f))/unlicensed residential settings (serving one adult)), in the community, in certified Adult Day Health/Adult Day Care (131 D) facilities, and Day Support facilities (2300 facilities). Institutional Respite may be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) facility.

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

- NC Innovations: Residential Supports (provided in 5600 b and c group homes, licensed 5600(f) AFLs, and unlicensed AFLs), Day Supports (provided in 2300 licensed day programs and adult day health/care programs certified under 131D), and Supported Employment
- CAP/DA and CAP/Choice waivers: Adult Day Health (certified under 131D)
- 1915(b)(3) services: Supported Employment (IDD/MH/SAS) and the De-institutionalization service array services of Day Supports, Supported Employment and Residential Supports.
- Foster care settings under all 1915(c) waivers per clarification from CMS in December 2015.

North Carolina determined that no services under the CAP/C waiver would be affected by the HCBS Final Rule as the services are based in the home; however, foster care settings under CAP/C will be assessed even though the family is not being paid to provide services under the waiver.

It is presumed that individual homes meet the HCBS Rule.

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 seven 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 Medical Assistance (DMA) 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. DMA will have direct oversight 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 was the Community Alternatives Program for Individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD) and the other was Cardinal Innovations waiver (which has since become the North Carolina Innovations waiver). During the course of renewing the CAP-MR/DD waiver and expanding the North Carolina Innovations waiver, DHHS had conversations with CMS around the then "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 residential settings:

> "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 that the individual has an active role in directing the process
- Person centered planning process must be at convenient locations and times for the individuals to attend
- Ensure there are opportunities for the person centered plan 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 residing 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.

Non-Disability Specific Settings:

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, Private Homes meet HCBS characteristics, 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; monthly if they receive services by a relative/guardian that resides with them. If they are self-directing their services or have a

relative in the home as a provider, then Care Coordination is at least monthly. Any concerns with the individual's rights would be reported to the LME-MCO or the LLA.

Stakeholder Engagement

HCBS Stakeholder Advisory Committee

Conversations about the HCBS Final Rule began in Spring 2014 and generated valued stakeholder input. At the heart of the engagement effort is the HCBS Stakeholder Advisory Committee, convened by DHHS. This group worked closely together to develop and implement a shared approach for crafting North Carolina's Statewide Transition Plan. In addition, DHHS established a full complement of personnel to work in collaboration with the Stakeholder Committee to ensure North Carolina's primary full compliance with the HCBS Final Rule. 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 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
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)

Provider Organizations and Agencies

Peggy Terhune, Ph.D., Monarch, Inc. (Provider)
Bridget Hassan, Easterseals 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 Carter, Vaya Health (formerly Smoky Mountain LME-MCO)
Foster Norman, CoastalCare (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 Medical Assistance (DMA)
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 (DSOF)

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 January. 16, 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, 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 CFACs meetings; meetings with provider organizations and LME-MCOs/Local Lead Agencies. Across the state, DHHS leadership met face-to-face with attendees at various sessions. Participants shared personal experiences with services, helping DHHS to 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. 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

Concern/Suggestion	Frequency
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 participants 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. 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	CORRESPON-DENCE	FAX	SESSION ATTENDEES	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 communications via provider organizations and the broader stakeholder community. The public comment period provided interactive opportunities for dialogue with all vested partners.

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	CORRESPON-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%

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 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 Medical Assistance (www.ncdhhs.gov/dma/lme/Innovations.html) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Service (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.

Training

DMA 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/DMA/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.

DMA, 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

DHHS is working in partnership with, Disability Rights of North Carolina (DRNC) to develop a series of webinars regarding guardianship, alternatives to guardianship, and HCBS. These webinars will be posted to our website.

Assessment

North Carolina Rules

The Division of Health Service Regulation, Division of Medical Assistance, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has identified 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:

- Supports HCBS: All elements support the requirements of the HCBS rule.
- Not in conflict with HCBS: Not contrary to the rule. Some elements may support the requirements of HCBS rule.
- Conflicts with HCBS: At least some elements conflict with the requirements of the rule.

Meetings with DHHS Divisions who are responsible for these rules will be held by 12/31/16. Suggested changes to these rules will be drafted by 3/31/17. DHHS will submit any rules that conflict with the HCBS final rule to the appropriate Division's Rules Review Commission to recommend that the rules be altered to be in compliance with the rule or be removed by 6/30/17.

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." NCGS 150B-1(d)(9). As such, DMA Clinical Coverage Policies also carry the weight of rule. New rules will not need to be created where the current rules are silent. This will be addressed in the waivers and/or Clinical Coverage Policies.

Waiver Policy

Although an integral component of the current waivers, DHHS continues to assess its person centered planning and thinking processes concurrent with the HCBS Final Rule process. DMA has amended the Innovations waiver and policy to be in compliance with HCBS. The policy Clinical Coverage 8P has been updated and is posted to our website. DMA will update the existing CAP/DA and CAP/C waivers and policies (3K-1 Community Alternatives Program for Children, 3K-2 Community Alternatives Program for Disabled Adults and Choice Option) to include the HCBS standards by 1/31/1t for CAP/DA and 3/1/17 for CAP C. The process for ensuring these standards are maintained also will be incorporated into waiver policy. The policy will be put into operation through the regular DMA policy process. The changes will be added to subsequent waiver amendments and submitted to CMS for review and approval.

DHHS, through DMH/IDD/SAS, will review, revise and adopt policy relative to its vision, outcome measures and core indicators to ensure full compliance with the HCBS Final Rule. 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. The DHHS will provide 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. DMA has received eight LME-MCO attestations and 26 Local Lead Agencies attestations. Since receiving these, two of the LME-MCOs have merged. These attestations will be reviewed by the DMA and DMH/DD/SAS team by 12/31/16. Additionally, a desk review of the policies and procedures are completed during the annual EQRO 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 has 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

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 of the required waiver elements and was universally understood. The initial plan for the self-assessment involved all of the LME-MCOs and a random sample of Local Lead Agencies. It included a defined number of providers (not to exceed 108) representative of large, medium and small providers from each of the 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 should reflect 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, whichever is larger. After the initial self-assessment process, individual job sites will not be required to undergo self-assessment as discussed with CMS on September. 25, 2015. Providers will submit self-assessments, along with the evidence of compliance, to the assigned LME-MCO/DMA) 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.

DHHS, 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, with initial analysis, is projected to be complete by June 15, 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. DMA 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

The heightened scrutiny (HS) process is to be completed for all providers who have been identified as:

- in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- located in a 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.

The e-Review process includes a function that immediately denotes if a setting or site has the qualities of an institution. Once identification occurs, DHHS has engaged a process through the development of threshold assessment to determine if heightened scrutiny is warranted. The LME-MCO and DMA will share the form with the provider agency if it appears that heightened scrutiny may apply.

The provider will have ten (10) working days to complete and return the threshold assessment. Follow up will occur as indicated based on the review of the form within five working days. If the site is not found to warrant heightened scrutiny, the assessment process will continue as with any other provider. If the site is found to warrant heightened scrutiny, then a desk review will be completed within five business days of the receipt of all documents submitted. Onsite visits will be scheduled within 10 business days of the receipt of all documents and will be conducted within 60 days. A committee of DHHS, LME-MCO, and DMA (CAP/DA) staff will review all results from the desk and onsite reviews within 30 days of the onsite review. If DHHS 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 DHHS determines that the site cannot overcome the institutional presumption, then DHHS will work with the LME-MCOs/Local Lead agencies, individuals and families, and providers on the transition of these individuals to sites that meet the HCBS rule. (Please see attached Heightened Scrutiny document.)

To help ensure that North Carolina has adequately and appropriately identified sites that may require heightened scrutiny, the practice of geo-mapping is being readily explored by DHHS as a viable option.

DHHS has not identified any providers that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; nor do any settings that are in a building on the grounds of, or immediately adjacent to, a public institution. 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. DMA and DMH/DD/SAS will be conducting

desk reviews and site visits on the other two sites, and any others that are identified, to determine if they can overcome the institutional presumption.

My Individual Experience Survey

Based on stakeholder feedback, DHHS 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, DMH/DD/SAS and DMA also enlisted the assistance of DHHS's 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.

There are four separate surveys for the "My Individual Experience" survey (MIE): 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, DMA and the LME-MCOs will use Raosoft (http://www.raosoft.com/samplesize.html). DMA 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, 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 DMA (CAP/DA). Through this portion of the monitoring process, feedback will be available to DMA, 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 October 25, 2016, a total of 728 surveys had been received. By services, they are as follows:

Adult Day Health	38
Day Supports	298
Residential	279
Supported Employment	113

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 DHHS, LME-MCO and DMA CAP/DA staff will be alerted to follow up. DHHS 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/DMA

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 DHHS annually.

Initial Data on Provider Self-Assessment

Data Analysis for January 2016

The following is an overview of January 2016 Reports from the LME-MCOs and DMA. The next report is due January 2017. As of the writing of this transition plan update, 1,726 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. DMA chose to not use the word 'compliance' as we wanted the mindset to be one of not just checking boxes and being compliant, but of integrating the HCBS philosophy into the service system. Please note that the Self-Assessment Review Guide used by DMA and the LME-MCOs outlines the expectations of Full Integration, Emerging Integration, Insufficient Integration and Additional Information Needed.

Assessments in System

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

Assessments with Ratings from DMA/LME-MCOs

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?

Service	Need Additional	Emerging	Full	Insufficient	Total

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

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 people choose their rooms (if residence) or the area they work in, etc.?

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

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?

Service	Need Additional Information	Emerging Integration	Full Integration	Insufficient Information	Total
Adult Day Health		0	26	0	26

(b)(3) Supported Employment		15	210	0	225
(b)(3) DI Services		5	9	0	14
Day Support		36	307	1	344
Residential Supports		368	2144	0	2512
Supported Employment		107	653	1	761
Total		**531**	**3349**	**2**	**3882**

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?

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

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?

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

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

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?

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

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?

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

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?

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

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

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?

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**

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?

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**

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

- Do people choose their roommates?

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

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?

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**

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?

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**

Remediation

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 time lines. 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, with the goal of full compliance for all providers by March 31, 2018. 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 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 DMA. Acceptance indicates that the information as presented has been reviewed and the plan to meet 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 or DMA. Reviewing entities will adhere to the thresholds established in the plan and will be submitting ongoing analysis to DHHS. All reviews can be accessed by DHHS throughout any phase of this process, thus making it seamless, streamlined and manageable in real time by all parties.

If the LME-MCO/DMA requests a self-assessment or follow-up information and does not receive the information via the web tool, then the LME-MCO/DMA 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/DMA receives no response within five business days, written correspondence will be sent to the provider. If a response is not received within 10 days of the correspondence being sent, the LME-MCO/DMA 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 30-day deadline from date of issuance to conform fully. If compliance does not occur within 30 days, the provider will be prohibited from providing the service in question at that site until such time there is full compliance with the 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 60-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/DMA. Assigned LME-MCO or Local Lead Agency/DMA staff and DHHS staff 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 14 days after becoming aware that a new service option needs to be pursued to discuss the transition process and ensure the individual and family has been fully informed of any applicable due process rights.

DHHS in partnership with the LME-MCO/Local Lead Agency, 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 March 31, 2018. 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 June 30, 2018. DHHS will monitor the transition of individuals monthly until the transition is complete. DHHS and the LME-MCOs/Local Lead Agencies will oversee all necessary transition processes.

Ongoing Monitoring/Compliance

Analysis of the self-assessment data from the LME-MCO and DMA was submitted to DHHS for review by March 31, 2016. DMA Behavioral Health, DMA Long Term Care team and DMH/DD/SAS IDD team will review these 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 DMA.

Acceptance of the assessment indicates that the information submitted by the provider is either in full compliance with 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 TA as needed with progress reviewed at six months, one year, two years and three years, with the goal of full compliance for all providers by March 2018. LME-MCOs and DMA will follow up at the defined intervals with the providers and will be submitting updated analyses at least annually. DHHS will review a sample of reviews completed by the PIHPs to ensure consistency of reviews.

DHHS has developed a HCBS monitoring tool that will be incorporated in the State's current Monitoring Process that will be used for all LME-MCO providers (Medicaid and State services). This monitoring process occurs every two years. The HCBS monitoring workbook was created to be a part of the existing monitoring or as a standalone tool if HCBS concern is identified outside of the annual monitoring process. For CAP/DA and CAP/Choice ongoing monitoring, this will be streamlined into the regular monitoring completed by the Local Lead Agency Case Manager. Information received from the completion of the "My Individual Experience Survey" will be used to monitor individual experience at the HCBS site.

Care Coordinator/Case Management monitoring will continue, ensuring that participants are receiving services consistent with their person-centered plan and CMS requirements. 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).

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

- Regular solicitation of feedback from individuals supported through the waiver, providers, provider organizations and LME-MCOs/Local Lead Agencies;
- Annual consumer satisfaction surveys;

- Regular review of contracts with LME-MCOs/Local Lead Agencies (Case Management Entities) to ensure ongoing compliance with standards;
- Identification or development of specific quality assurance/improvement measures that ensure compliance with the HCBS Final Rule;
- Ongoing use of the My Individual Experience Survey.
- Continuation of a collaborative monitoring oversight process between the LME-MCOs/Local Lead Agencies 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 technical assistance and education to individuals and their families, LME-MCOs/Local Lead Agencies, Provider Community and broader stakeholder community will be provided;
- 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.

Validation

DHHS and the LME-MCOs/DMA will establish a Monitoring Review Process to review a statistically valid sample (using Raosoft calculator www.raosoft.com/samplesize.html) of provider self-assessments after the LME-MCO/DMA review of the assessments is completed. This desk review will confirm overall integrity of the self-assessment process. This monitoring process will begin November 2016 and will occur no less than annually. DHHS will also review a sample of provider monitoring done by the LME-MCO to validate the monitoring process. DHHS will review LME-MCO/Local Lead Agency policies and procedures during their annual review to ensure that they are in compliance with HCBS.

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 SE, DS, and RS to be included: **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 DMA 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, 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.	11/25/2014	1/15/2015 Completion: 1/15/2015
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	11/25/2014	03/16/2018
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.	8/12/2015	9/30/2015

General Milestones	Start date	End date
Outcome: e-Review Heightened Scrutiny Tool		
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 session of NCGS is held biennially convening in January after election –January. 14, 2015.	11/25/2014	9/7/16
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 Completed 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. CMS granted this three-day extension on August. 25, 2015. **Outcome**:	7/15/2015	9/15/15 Completion: 9/15/2015
(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 DMA staff to review self-assessments. **Outcome:** e-Review tool developed.	5/4/2015	8/31/2015 Completion: 8/18/2015

General Milestones	Start date	End date
Develop and distribute e-Review companion document: Develop an e-Review companion document to offer guidance to LME-MCO and DMA 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 MCOs and DMA: LME-MCOs and DMA will review pilot self-assessments. **Outcome:** Provider self-assessments reviewed by LME-MCO and DMA.	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
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 Completed 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. **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 Completed 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. **Outcome:** Individual Experience Assessment. Implemented 8/25/16.	7/21/2015	8/25/2016 Completion: 8/25/2016
Establish a Monitoring Oversight Process to validate representative sample of Provider Self-Assessments: Process will ensure integrity of the self-assessment process. LME-MCO Designated Departments; e.g., Care Coordination / Quality Management and DHHS / DMA / DMH/DD/SAS Accountability and Quality Management Sections and Local Lead Agencies (Case Management Entities) designated staff will validate a percentage of provider self-assessments for validity (initial assessment data in comparison to validation data). **Outcome:** Validate Provider Self-Assessment. Random Sample - sample not to exceed 108.	10/1/2015	11/30/2016
Analysis of the self-assessment data from the LME-MCOs and DMA is due by March 31, 2016. **Outcome**:	1/1/2016	3/31/2016 Completed 3/31/16

General Milestones	Start date	End date
Section 3. Remediation	03/17/2015	03/16/2018
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, 2018. **Outcome**: All network providers in compliance with HCBS.	9/16/2016	3/15/2018
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:** Institute Legislative Administrative Code changes and Department Policy (development/modification) to ensure compliance with the HCBS Final Rule.	11/25/2014	3/16/2018
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 with CMS on September. 25, 2015. Will submit response as requested by CMS. **Outcome:** Updated Transition Plan submitted.	8/12/2015	10/22/2015 Completed: 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	3/16/2018
Policy Development: HCBS will develop/revise Innovations policy to ensure compliance with HCBS Final Rule. **Outcome:** Approved Policy.	12/12/2014	3/16/2017
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
Technical Assistance/Advisement to LME-MCOs/Local Lead Agencies and Provider Community: DHHS/DMA - 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	3/16/2018
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 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.	3/16/2015	3/16/2018
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.	4/1/2015	12/31/2016

General Milestones	Start date	End date
Outcome: Waiver Amendment with encumbered language reflected from Transition Plan.		
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 Completed: 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 Completed 1/13/17
For providers needing compliance assistance, DHHS proposes the following strategies from July 1, 2015, through June 30, 2018: 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. 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.	7/1/2015	6/30/2018
Section 4. Outreach, Engagement and Public Notice/Comment	10/1/2014	03/17/2018
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 also 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 also 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
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

General Milestones	Start date	End date
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, NC Council on Community Programs - Pinehurst. **Outcome:** Increase and improve public awareness and knowledge of HCBS.	3/1/2015	3/16/2018
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	3/16/2018
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	3/16/2018
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 all of us. We affirm our dedication to working in partnership with people who use, or seek to use, home and community based waiver services, their families, allies and other valued stakeholders, to affect change.