Individuals may obtain information and select a residential facility and provider of 1915(i) services from many different sources, such as local DSSs, hospital discharge planners, local aging agencies, local management entities for MH/DD/SA services and aging and disability resource centers. These entities have up-to-date information on adult care homes and supervised living facilities and assist applicants/responsible parties in locating a provider that meets their needs and preferences. In addition, North Carolina has recently implemented a star rating system for adult care homes, which was specifically established in response to requests of North Carolina citizens for increased availability of public information on the quality of care provided in adult care facilities. The rules are based on General Statute 131D-10, and were created by the NC Medical Care Commission with input from residents and families in adult care homes, advocacy groups, providers, and others. Star ratings are based on the results of annual inspections and follow-up surveys by the NC DHHS Division of Health Service Regulation (DHSR)and certain rules violations. Star ratings, as well as rules violations and penalties, are posted on the DHSR website. The referral organizations above make sure the potential participant/responsible party is aware of the availability of this information to aid them in making an informed choice among providers.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

Either the State or its HCBS quality improvement contractor will conduct quality assurance activities to assure that the plan of care meets all federal and state requirements.. Any issues or concerns with regard to service plan content and approval will be identified and appropriate corrective action will be taken by the State.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other *(specify):*	Provider			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: HCBS Residential Services

Service Definition (Scope):

Home and Community Based Residential Services (HCBS - Residential) consist of assistance with the following tasks as well as supervision and prompting an individual's self-performance of the tasks:

- Toileting and maintaining bowel and bladder continence;
- Mobility and transferring;
- Care for normal, unbroken skin;
- Personal hygiene;
- Bathing and grooming;
- Trimming hair;
- Shaving;
- Basic first aid;
- Dressing;
- Feeding residents with no swallowing difficulties;
- Assistance/encouragement to participate in physical activities;
- Taking/recording temperature, pulse, respirations, height, weight;
- Trimming toenails without presence of diabetes or peripheral vascular disease;
- Perineal care;
- Apply condom catheters;
- Turn and position;
- Collection of urine and fecal specimens;
- Take/record blood pressure if RN has documented staff competency;
- Empty/record drainage of catheter bag;
- Testing of urine and fecal specimens;
- Non-sterile dressing procedures;
- Force/restrict fluids;;
- Administration of drugs as required by licensure rules;
- Supervision of residents as required by licensure rules;
- Non-emergency medical transportation.

In addition, the following tasks may be performed by aides in adult care homes but require licensed health professional support as defined in Title 10A of the North Carolina Administrative Code, Chapter 13F.0903. The rule requires that an appropriate licensed health professional participate in the on-site review and evaluation of the individual's health status, care plan and ongoing care when the following types of personal care assistance are needed by a resident of an adult care home:

- Applying/removing ace bandages, ted hose and binders;
- Feeding residents with swallowing problems;
- Bowel or bladder training to regain continence;
- Enemas, suppositories and vaginal douches;
- Positioning and emptying urinary catheter bag and cleaning around catheter;
- Chest physiotherapy or postural drainage;
- Clean dressing changes;
- Collecting and testing of finger stick blood samples;

- Care of well established colostomy or ileostomy;
- Care for pressure ulcers;
- Inhalation medication by machine;
- Maintaining accurate intake/output data;
- Medication administration through gastrostomy feeding tube;
- Medication administration through injection;
- Oxygen administration and monitoring;
- Care of residents who are physically restrained and use of care practices as alternatives to restraints;
- Oral suctioning;
- Care of well established tracheostomy;
- Gastrostomy tube feedings.

Home and Community Based Residential Services are provided at three levels: basic, enhanced and enhanced/special care unit. Basic HCBS Residential Services is for individuals who need minimal assistance with daily living tasks and/or supervision due to mental or physical impairments. Enhanced HCBS Residential Services is for individuals who need extensive assistance with eating, toileting, and/or ambulation/locomotion. Enhanced HCBS Residential Services/special care unit is for individuals with Alzheimer's or related disorders, as recognized by the Alzheimer's Association. Both enhanced HCBS Residential Services and enhanced HCBS Residential Services/special care unit must be prior approved, respectively, by the local department of social services and the State Medicaid Agency.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

☐ Categorically needy *(specify limits)*:

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Care Homes	Licensed in accordance with NC General Statute 131D and North Carolina Administrative Code Title 10A, Chapter 13, Subchapters F and G.		Service is provided by the Adult Care Home either through their own staff or through qualified staff under contract to provide the service. Staff providing services must meet the training, competency and other requirements applicable to direct care workers found in 10A NCAC 13F and 13 G. Staff who prepare and administer medications must meet all applicable requirements for medication aides in 10A NCAC 13F and 13G. Medications must be stored, maintained and managed according to

			the requirements of 10A NCAC 13F and 13G. Criminal records and health care registry checks are required for all adult care home staff. If DMA or a contractor working on behalf of DMA finds that a provider is out of compliance with waiver requirements, DMA may require a corrective action plan. If a corrective action plan is not implemented or does not resolve the compliance issues, DMA may terminate the provider from participating in the program.
Supervised Living			•Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200. •Staff must have a high school diploma or GED •Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan. •Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training. •Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. •Must have a criminal record check •A healthcare registry check is required in accordance with 10A NCAC 27G.0200 If DMA or a contractor working on behalf of DMA finds that a provider is out of compliance with program

			requirements, DMA may require a corrective action plan. If a corrective action plan is not implemented or does not resolve the compliance issues, DMA may terminate the provider from participating in the program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Care Homes	**The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses adult care homes.**	**Annually**
Supervised Living	**The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses supervised living homes.**	**Annually**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Services may not be provided by relatives and/or legal guardians of 1915(i) participants.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** (*Select one):*

⊙	The State does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

3. **Limited Implementation of Participant-Direction.** (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option)*:
	N/A

4. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
N/A	☐	☐
	☐	☐

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

⊙	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

☑	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

☑	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.

N/A

Quality Improvement Strategy

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

***The State is in the process of determining whether State staff or its contracted HCBS QI entity will conduct the following activities and is identifying data sources and activities that are already in place. Several DHHS agencies are required by State law to monitor these facilities and our intent is to develop a comprehensive plan that is not duplicative.**

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.		To be determined*				
Providers meet required qualifications.	Percent of providers due for license renewal who had licenses renewed in a timely manner. Percent of individuals surveyed who indicate that their providers are effectively providing waiver services.					
The SMA retains authority and responsibility for program operations and oversight.	Contract with QI entity for specific quality assurance and improvement activities; Set up oversight committee involving all parties with 1915(i) monitoring responsibilities. The committee will					

	meet at least quarterly and monitor the program through reports from the quality improvement contractor, the performance measures specified in this application and other quality assurance activities.					
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Percent of participants whose paid claims for waiver services were authorized by the plan of care.					
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.						

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
See below. Intradepartmental Oversight Committee, consisting of DHHS staff and providers will work together to identify and prioritize issues.	Provider representatives as well as representatives from all DHHS divisions who work with adult care and supervised living homes will participate.	Quarterly meetings	Findings by quality improvement contractor and other monitoring activities will be presented to the oversight committee.

The overall purpose of the Quality Improvement Strategy (QIS) for the 1915(i) program is to design, develop, implement, and manage a quality assessment and improvement program that:

- Meets all CMS requirements and assurances for 1915(i) program services;
- Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of 1915(i) services;
- Identifies and sets appropriate performance and outcome measures to evaluate 1915(i) services; and
- Focuses on outcomes related to:
    - Service plans based on assessed needs
    - Choice of providers (adult care homes)
    - Qualified providers
    - Financial accountability
    - Participant safeguards (prevention of abuse/neglect)

There are a number of parties required by State law and rule to conduct specific oversight and remediation activities, including the local departments of social services, local aging agencies, community advisory committees for adult care homes, service providers, and several divisions within the NC Department of Health and Human Services. In order to achieve the QIS goals listed above, the parties need to work together collaboratively and systematically. The State will therefore implement a 1915(i) program oversight committee with representation from these parties/entities. The primary functions of the oversight committee will be to ensure that all 1915(i) program requirements are implemented appropriately; monitor quality of care through 1915(i) performance measures and other monitoring activities; and implement system design improvements that will enhance consumer satisfaction and quality of care. The group will review findings from 1915(i) program performance measures and other quality assurance activities, identify opportunities for improvement or correction and prioritize the desired system changes. The oversight committee will maintain a corrective action plan (CAP) outlining improvements or changes that need to be made, timeframes for completion, progress, and responsible parties. The CAP will be reviewed at least quarterly, with items added and deleted as approved by the group.

DMA and the 1915(i) program oversight committee will monitor effectiveness of system design changes to ensure that the intended improvements are being achieved. New performance measures will be established to monitor the design changes if appropriate. The parties involved in specific design changes will depend on the subject area of the change.

The quality improvement strategy will be reviewed annually by the 1915(i) program oversight committee; the first review will take place one year after the implementation of 1915(i) performance measures and every twelve months thereafter.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
✓	HCBS Residential Services
	The Division of Medical Assistance shall enter into agreements with Adult Care Home providers and Supervised Living Homes in accordance with 42 CFR 431.107 for the provision of HCBS Residential Services for State/County Special Assistance clients and those clients described in 42 CFR §435.135 residing in Public and Private Adult Care Homes and Supervised Living Homes. Reimbursement is determined by the Division of Medical Assistance based on a review of industry costs and determination of reasonable costs with annual inflation adjustments. The initial basic fee was based on service per resident day. The initial basic fee was computed by determining the estimated salary, fringes, direct supervision and allowable overhead. Effective January 1, 2000 the cost of medication administration and HCBS Residential Services direct supervision were added to the basic rate. Additional payments are made utilizing the basic fee as a factor for a Medicaid eligible resident that has a demonstrated need for additional care. The enhanced rates include eating, toileting, ambulation/locomotion or special care units (Alzheimer's) which are added to the initial basic rate. The agency's fee schedule rate was set as of October 1, 2004 and is effective for services provided on or after that date. All rates are published http://www.ncdhhs.gov/dma/fee/index.htm. The rates were calculated from a cost reporting period selected by the state thereby developing the established fee schedule. The fees are reviewed annually and adjusted using the Medicare Home Health index, not to exceed that amount allowed by the North Carolina General Assembly. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 2, page 1 to the 4.19-B section of the state plan.

Effective January 1, 2000, payments to providers were cost settled with any overpayment repaid to the Division of Medical Assistance. The first cost settlement period was for the nine months ended September 30, 2000. Subsequently, the annual cost settlement period shall be the twelve months ending September 30. No additional payment will be made due to cost settlement. Through review of annual provider cost reports, any provider receiving payments in excess of cost would have monies recouped and returned to the North Carolina Department of Health & Human Services (NCDHHS) Controller's Office with the federal share returned via the CMS 64 cost report. Methodology listed above will be end dated effective May 9, 2010, all payments for cost reporting periods ending on and after December 31, 2009 shall be prospective and not subject to cost settlement.

Effective May 10, 2010, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS Residential Services in Adult Care Homes. The agency's fee schedule rate was set as of October 1, 2009. All rates are published at http://www.ncdhhs.gov/dma/fee/index.htm.

The initial basic fee was based on 1.1 hours of service per resident day. The initial basic fee was computed by determining the estimated salary, fringes, direct supervision, cost of medication administration, and allowable overhead. Reimbursement does not include room and board in the rate. Additional payments are made utilizing the basic fee as a factor for a Medicaid eligible resident that has a demonstrated need for additional care. The enhanced rates include eating, toileting, ambulation/locomotion or special care units (Alzheimer's) billed in addition to the initial basic using the appropriate published HCPCS code for the enhanced service rendered.

☐ HCBS Adult Day Health

☐ HCBS Habilitation

☐ HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐ HCBS Day Treatment or Other Partial Hospitalization Services

☐ HCBS Psychosocial Rehabilitation

☐ HCBS Clinic Services (whether or not furnished in a facility for CMI)

Intentionally Left Blank

23. f. In-Home Care Services

a. The number of hours of In-Home Care Services received by a Medicaid beneficiary may not exceed eighty (80) hours per calendar month for adults and sixty (60) hours per calendar month for children. The number of hours needed is determined through an independent assessment which in turn provides prior authorization for the number of hours received by the beneficiary.

b. Licensed home care agencies are enrolled for In-Home Care Services rendered in private residential settings. In-Home Care Services may only be rendered outside of private residential settings in order to assist eligible individuals with obtaining and maintaining competitive employment. The agency must be a State licensed home care agency that is approved in its license to provide in-home aide services within the State. Licensed home care agencies are required to perform the following activities to comply with state laws:

1. Complete background checks on all employees,
2. Conduct in-home aide competency evaluations and trainings,
3. Monitor quality of care,
4. Handle Workers' Compensation,
5. Manage the payment of income and Social Security taxes, and
6. Ensure that in-home aides work under the supervision of a Registered Nurse.

TN No. 10-034
Supersedes
TN No. 10-031

Approval Date: _____

Eff. Date 04/01/2011