

## 1915(i) State plan Home and Community-Based Services

### Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

NC Home and Community Based Residential Services

2. **Statewideness.** *(Select one):*

<input checked="" type="radio"/>	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one):*

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :	
<input checked="" type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :	Division of Medical Assistance, North Carolina Department of Health and Human Services
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

**4. Distribution of State plan HCBS Operational and Administrative Functions.**

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any – NO LIMITS	<input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> And providers
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> And providers
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Item 3: Physicians/providers determine functional eligibility. Local departments of social services determine financial eligibility on behalf of the State Medicaid Agency.

Item 4: Either a contracted QI vendor for home and community based services or the State Medicaid Agency reviews a sample of service plans.

Item 5: The individual's physician authorizes basic HCBS Residential Services; the DSS authorizes enhanced services, except that when services in special care unit for Alzheimer's and related disorders are needed, the State Medicaid agency conducts the prior authorization.

Item 7 and 8: The State Medicaid Agency's MMIS contractor assists the state with provider enrollment tasks.

Item 11: The contracted QI vendor or the State Medicaid Agency conducts specific QI activities.

(By checking the following boxes the State assures that):

5.  **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
  - financially responsible for the individual
  - empowered to make financial or health-related decisions on behalf of the individual
  - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6.  **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7.  **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8.  **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.



## Target Group(s)

Participation in the 1915(i) program is limited to the assisted living target group, which consists of: 1) adults 18 years of age and older who receive State/County Special Assistance and reside in adult care homes licensed in accordance with NC General Statute 131D and North Carolina Administrative Code Chapter 10A, subchapters F and G; and, 2) adults 18 years of age and older who receive State/County Special Assistance and reside in Supervised Living Homes licensed according to NC General Statute 122C and North Carolina Administrative Code Title 10A, Chapter 27G.5600 and designated as types A and C homes. (State/County Special Assistance is an optional state supplement cash payment program for disabled and elderly adults.)

## Number Served

**1. Projected Number of Unduplicated Individuals To Be Served Annually.**

*(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	4/1/2011	3/31/2012	30.000
Year 2	4/1/2012	3/31/2013	30.900
Year 3	4/1/2013	3/31/2014	31.830
Year 4	4/1/2014	3/31/2015	31.760
Year 5	4/1/2015	3/31/2016	32.700

**2.  Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

**3. Optional Annual Limit on Number Served.** *(Select one):*

<input checked="" type="checkbox"/>	The State does not limit the number of individuals served during the year or at any one time. <b>Skip to next section.</b>			
<input type="checkbox"/>	The State chooses to limit the number of <i>(check each that applies):</i>			
	Unduplicated individuals served during the year. <i>(Specify in column A below):</i>			
	Individuals served at any one time ("slots"). <i>(Specify in column B below):</i>			
			<b>A</b>	<b>B</b>
Annual Period	From	To	Maximum Number served annually <i>(Specify):</i>	Maximum Number served at any one time <i>(Specify):</i>
Year 1				
Year 2				
Year 3				
Year 4				
Year 5				
<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). <i>(Specify):</i>			

**4. Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

<input checked="" type="checkbox"/>	The State will not maintain a waiting list.
<input type="checkbox"/>	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

## Financial Eligibility

1.  **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):* **Need assistance from Andy Wilson to complete this one.**

<input checked="" type="checkbox"/>	The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="checkbox"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input type="checkbox"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

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## Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one):*

<input type="checkbox"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i> Providers enrolled with the State Medicaid Agency.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The independent assessment is conducted by the individual's medical doctor.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The individual's physician documents functional eligibility for 1915i participation using either the FL-2 or MR-2 assessment form. These are the same tools that the State uses to determine eligibility for nursing facility and ICF-MR care and for 1915(c) waivers. The forms document the person's overall health status, diagnoses, medications, physical and

mental functional status, and need for assistance with activities of daily living and/or supervision. This assessment determines eligibility for entrance to an adult care or supervised living home as well as the basic level of HCBS Residential Services, as described in the "Services" section of this application. Eligibility for HCBS Residential Services at the enhanced levels is determined by the local departments of social services. If, after the individual has been admitted to the facility, the HCBS Residential Services provider believes that enhanced HCBS Residential Services are needed, the provider refers the individual for further assessment by social workers at the local department of social services.

This assessment process is completed annually by the physician. An individual can be referred for assessment for enhanced services at any time the HCBS Residential Services provider identifies the need for further evaluation.

4.  **Needs-based HCBS Eligibility Criteria:**

**Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The following are the list of requirements for all recipients to qualify for participation in NC's HCBS State Plan Services:

1. Recipient is eligible for participation in the State and County Special Assistance Program and is willing to reside in a home licensed in accordance with NC General Statute 131D and North Carolina Administrative Code Chapter 10A, subchapters F and G (licensed adult care homes and licensed family care homes), or licensed in accordance with NC General Statute 122-C and 10A NC Administrative Code 27G 5600 (type A and C Supervised Living Facilities).
2. Recipient, Guardian, or Responsible Party agrees to adhere to the rules of the home and participation in person centered activities to his/her level of ability.
3. Independent Assessment indicates that a health risk to safety and security exists due to the recipient's lack of a capable and willing caretaker to assure that his/her health and welfare needs are met in a private residence due to a cognitive or chronic condition, disability, progressive disease or whose impairment is related to the individual's diagnosis and impedes his use of skills necessary for independent functioning in the community.

And at least 2 of the following functional criteria

1. Need for ongoing supervision.
2. Need for medication assistance or medication Administration.
3. Assistance with at least two Activities of Daily Living (ADL's) at the limited, extensive or total assistance level (toileting, eating, ambulation, bathing, personal hygiene, dressing and transferring).
4. Assistance with IADLs (light housework, preparation of meals, medications on time and correctly, shopping for clothes and/or groceries, use of the telephone, management of money and use of technology to the level of their ability).

For admission to a home licensed under NC General Statute 131-D (adult care home or family care home). The recipient may also need:

1. Licensed Health Support services – according to 10A NCAC 13F 0903 specifying tasks through nurse delegation.
2. A secure Special Care Unit due to Alzheimer's or one of the related diseases. Related diseases are Vascular Dementia, Jakob-Creutzfeldt disease, Pick's Disease with Lewy bodies, Parkinson's Disease, Huntington's chorea.
3. Hospice

For admission into a home licensed under NC General Statute 122-C ( Supervised Living Home) the following are also required:

1. The recipient has an Axis 1 or 11 diagnosis or has a condition defined as a developmental disability.
2. Independent Assessment indicates the need for ongoing supervision in a residential licensed home which provides services only to adults who have a mental illness or a developmental disability.

#### Exclusionary Criteria

According to G.S.131D and 10A NCAC 13 F.0701 and 13G.0701 the following individuals are not to be admitted to Licensed Assisted Living:

1. Who are ventilator dependent
2. Who require continuous licensed nursing care
3. For treatment of mental illness or alcohol or drug abuse\*
4. Who require maternity care
5. For lodging when the State Plan Home and Community Based Services are not needed
6. Whose physician certifies that placement is no longer appropriate
7. Whose health needs cannot be met in the specific licensed home as determined by the residence and/or his/her physician.
8. Who possess such other medical or functional care needs as the Medical Care Commission or the Mental Health Commission determines cannot be properly met in a 131 –D or 122C licensed home.
9. Whose admission is a condition of discharge and a condition of release from prison.

\*Licensed supervised living homes under NC General Statute 122(c) are excluded from this criterion.

#### Aging in Place

As a resident resides in the licensed Assisted Living he/she may develop illnesses and or behaviors that will necessitate the review of his appropriateness to continue to stay in this level of care. An additional evaluation should be completed when a resident:

1. Develops medical condition that the home does not feel comfortable in providing the care or whose physician states that the resident needs another level of care to adequately meet his/her needs.
2. Develops a disease or condition that requires more than contact isolation.
3. Exhibits behaviors that are identified or documented by the home or a physician that the resident presents a threat to the health or safety of themselves or others or damage to property.
4. Fails to comply with the rules or policies of the home.\*
5. Engages in criminal behavior.

\*Licensed supervised living homes under NC General Statute 122(c) are excluded from this criterion.

5.  **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):*  
 There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

**Needs-Based/Level of Care (LOC) Criteria**

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
	<p>The following criteria are not intended to be the only determinants of the resident's or recipient's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or recipient's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives. All professional services that are provided to the resident or recipient to maintain, monitor, and/or enhance the resident's or recipient's level of health must be addressed in the medical records and reflected on the medical eligibility assessment form.</p> <p><b>Qualifying Conditions:</b>            Conditions that are considered when assessing a recipient</p>	<p>In order to be Medicaid-certified at an ICF/MR level of care, an individual must meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. Require active treatment necessitating the ICF/MR level of care; <b>and</b></li> <li>2. Have a diagnosis of mental retardation, Intelligence Quotient (IQ) test results indicating mental retardation, or a condition that is closely related to mental retardation.               <ol style="list-style-type: none"> <li>a. Mental retardation is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.</li> <li>b. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets <b>ALL</b> of the following conditions:                   <ol style="list-style-type: none"> <li>i. is attributable to:</li> </ol> </li> </ol> </li> </ol>	<p>Hospital level of care as defined in 42CFR 440.10</p>

	<p>for nursing facility level of care include the following:</p> <p>a. Need for services that, by physician judgment, require</p> <ol style="list-style-type: none"><li>1. a registered nurse for a minimum of 8 hours daily and</li><li>2. other personnel working under the supervision of a licensed nurse</li></ol> <p>b. Need for daily licensed nurse observation and assessment of resident needs</p> <p>c. Need for administration and/or control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 130.0202, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for supervision)</p> <p>d. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive</p>	<p>(a) Cerebral palsy, epilepsy; <b>or</b></p> <p>(b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; <b>and</b>;</p> <p>ii. The related condition manifested before age 22; <b>and</b></p> <p>iii. Is likely to continue indefinitely; <b>and</b></p> <p>iv. Have mental retardation or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:</p> <ol style="list-style-type: none"><li>(a) Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)</li><li>(b) Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)</li></ol>	
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	<p>disabilities as much as possible; such measures may include, but are not limited to, the following:</p> <ol style="list-style-type: none"><li>1. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transfer/ambulation)</li><li>2. Using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures</li><li>3. Training in ambulation and gait, with or without assistive devices</li></ol> <p>e. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician</p> <p>f. Nasogastric/gastrostomy tubes: requiring supervision and observation by licensed nurses</p> <ol style="list-style-type: none"><li>1. Tube with flushes</li><li>2. Medications administered through the tube</li><li>3. Supplemental bolus feedings</li></ol> <p>g. Respiratory therapy: oxygen as a</p>	<p>(c) Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)</p> <p>(d) Mobility (ambulatory, semi-ambulatory, non-ambulatory)</p> <p>(e) Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)</p> <p>(f) Capacity for independent living (age-appropriate ability to live without extraordinary assistance).</p> <p><b>Note:</b> Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.</p>	
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	<p>temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan</p> <ol style="list-style-type: none"><li>1. Nebulizer usage</li><li>2. Pulse oximetry</li><li>3. Oral suctioning</li></ol> <p>h. Wounds and care of decubitus ulcers or open areas</p> <p>i. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan</p> <p>j. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan</p> <p>k. Diabetes, when daily observation of dietary intake and/or medication administration is required for proper physiological control</p> <p><b>Conditions That May Justify a Nursing Facility Level of Care</b></p> <p>The following conditions may justify nursing facility level of care placement:</p> <ol style="list-style-type: none"><li>a. <b>Need for teaching and counseling</b> related to a disease process, disability, diet, or medication</li><li>b. <b>Adaptive programs:</b> training the resident to reach</li></ol>		
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	<p>his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must include the purpose of the resident's participation in the program and the resident's progress</p> <p><b>c. Ancillary therapies:</b> supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts</p> <p><b>d. Injections:</b> requiring administration and/or professional judgment by a licensed nurse</p> <p><b>e. Treatments:</b> temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction</p> <p><b>f. Psychosocial considerations:</b> psychosocial condition of each resident will be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care; factors to consider along with the resident's medical needs include</p>		
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	<p>1. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes)</p> <p>2. Age</p> <p>3. Length of stay in current placement</p> <p>4. Location and condition of spouse</p> <p>5. Proximity of social support</p> <p>6. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer)</p> <p>g. <b>Blindness</b></p> <p>h. <b>Behavioral problems</b> such as</p> <p>1. Wandering</p> <p>2. Verbal disruptiveness</p> <p>3. Combativeness</p> <p>4. Verbal or physical abusiveness</p> <p>5. Inappropriate behavior (when it can be properly managed at the nursing facility level of care)</p> <p>i. <b>Frequent falls</b></p> <p>j. <b>Chronic recurrent medical problems</b> that require daily</p>		
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	observation by licensed personnel for prevention and/or treatment		
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\*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

- 6.  **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
- 7.  **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii). However, if the State chooses to revise its needs-based eligibility criteria, it must continue offering 1915(i) services in accordance with individual service plans to participants who do not meet the new revised needs-based criteria, but continue to meet the former needs-based criteria, for as long as the State plan HCBS option is authorized.
- 8.  **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
  - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
  - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Adult Care Homes: NC General Statute 131D-4.1 states: "The General Assembly finds and declares that the ability to exercise personal control over one's life is fundamental to human dignity and quality of life and that dependence on others for some assistance with daily life activities should not require surrendering personal control of informed decision making or risk taking in all areas of one's life. The General Assembly intends to ensure that adult care homes provide services that assist the residents in such a way as to assure quality of life and maximum flexibility in meeting individual needs and preserving individual autonomy."

NC General Statute 131-D-19 implements a bill of rights for residents of adult care homes to ensure residents' right to privacy, autonomy, and independence, and the right to be treated with respect and dignity. The statute calls for residents to have maximum choice and decision making while putting processes in place to prevent abuse, neglect and exploitation. All residents receive upon admission to the adult care home a written copy of the bill of rights. State law requires adult care homes to provide and maintain specific services and living arrangements that promote a home environment which maximizes consumer choice, control and privacy, and enables consumers to participate in community activities. Specifically, the following requirements are in place:

- Telephones are available in locations providing privacy for residents to make and receive calls. (The resident cannot be required to use pay telephones for local calls.)
- Visiting in the home and community is encouraged and arranged by the administrator. Adult care homes must provide for visitation in the home at least 10 hours every day.
- All bedrooms are located on an outside wall off a corridor and must have windows low enough for the resident to see outdoors from a bed or chair. Bedrooms must be large enough to accommodate all furnishings and personal items needed by the resident.
- Dining rooms must be located off a corridor or lobby and fully enclosed with walls and doors and have windows. Meals are served family style for those who are physically able to participate at tables that seat two to eight persons.
- Bathrooms and toilet rooms must be designed to provide privacy.
- Living rooms must have functional furnishings for the comfort of aged and disabled persons.
- At least one washer and dryer must be available to and accessible by residents and their families.
- Residents manage their own funds if possible.
- The home must ensure that residents receive their mail promptly and unopened. Residents are encouraged and assisted, if needed, by staff to correspond by mail with family and friends.
- Adult care homes must assure transportation to shopping and recreational activities as well as religious activities of the resident's choice.
- Adult care homes must provide at least 14 hours of planned group activities per week. Residents must have input on types of activities desired.

Effective January 2009, the State implemented a star rating system. Each adult care home will receive a rated certificate after the annual survey. The rating will be based on the general statutes and rules governing adult care homes with a focus on residents' rights, care and services. The home's rated certificate status is available to the public.

Supervised Living: Supervised living homes (10A NCAC 27G .5603), which are group homes for adults with mental illness or developmental disabilities, can serve no more than six consumers at one time. The homes are located in residential neighborhoods in the community where residents are able to access community activities and day programs. Meals are served family style. State law requires that each resident have opportunities for activities based on his or her choices, needs and treatment or habilitation plan, and activities must be designed to foster community inclusion. Residents must be provided the opportunity to maintain ongoing relationships with their families and significant others through visits to the facility and outside the facility. The home must provide all residents and legally responsible persons with a summary of their rights as outlined in NC General Statute 122C, Article 3. Residents' rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation.

## Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1.  There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
  - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified as defined in 42 CFR §441.568 ;
  - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
  - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care as required in 42 CFR §441.565;
  - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
  - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
  - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2.  Based on the independent assessment, the individualized plan of care:
  - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
  - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
  - Prevents the provision of unnecessary or inappropriate care;
  - Identifies the State plan HCBS that the individual is assessed to need;
  - Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
  - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
  - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The individual's physician is responsible for conducting the face-to-face independent assessment and reassessments of the individual's functional needs and capabilities.

4. **Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Staff of adult care homes must develop care plans for all residents within 30 days of admission to the home. The care plan is an individualized, written program of personal care for each resident. The care plan is revised as needed based on further assessments of the resident and includes a statement of the care or service to be provided based on the assessment or reassessment and frequency of the service provision. The assessor signs the care plan upon its completion. The home assures that the resident's physician authorizes HCBS Residential Care services and certifies the following by signing and dating the care plan

- the resident is under the physician's care; and
- the resident has a medical diagnosis with associated physical or mental limitations that justify the HCBS Residential services specified in the care plan.

MH/DD/SAS Qualified Professionals develop care plans for all residents of supervised living homes. The plan is developed based on the assessment(s) and in partnership with the consumer and other individuals identified by the consumer. The plan includes the services and supports that will be provided, responsible party or provider, outcome(s)/goals and target dates. Assessments and care plans are completed as needs change and annually at minimum by the qualified professional

5. **Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Applicants in both types of homes are made aware of their right to be actively engaged in the service planning process through formal and informal communication, plan of care meetings, face to face meetings to update the plan of care, and meetings initiated by either the service provider or the participant to address any changes in the consumer's situation or preferences that would require changes in the service/care plan.

During the service plan development process, individuals are informed verbally of their authority to determine who will be included in the care planning process. The applicant/participant is the sole authority when making decisions unless a responsible party or guardian has been given authority to make decisions on the applicant/participant's behalf.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*