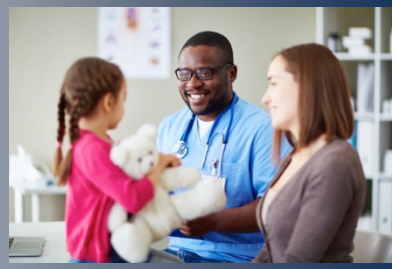






Adult Care Home Legislation Stakeholder Meeting

Long-Term Services and Supports

January 24, 2020

Welcome & Introductions

Meeting Objectives

- Share information on the Adult Care Home (ACH) payment methodology legislation and Medicaid's quality strategy.
- Engage in collaborative discussions on the Home- and Community-based Services Final Rule and statewide regulatory oversight of Adult Care Homes.

RL1

Agenda

- Review of Legislation
- Medicaid Overview
- Payment Methodology
- Home- and Community-based Services
- Final Rule
- Care and Quality Strategy
- Regulatory Overview
- Small Group Discussion

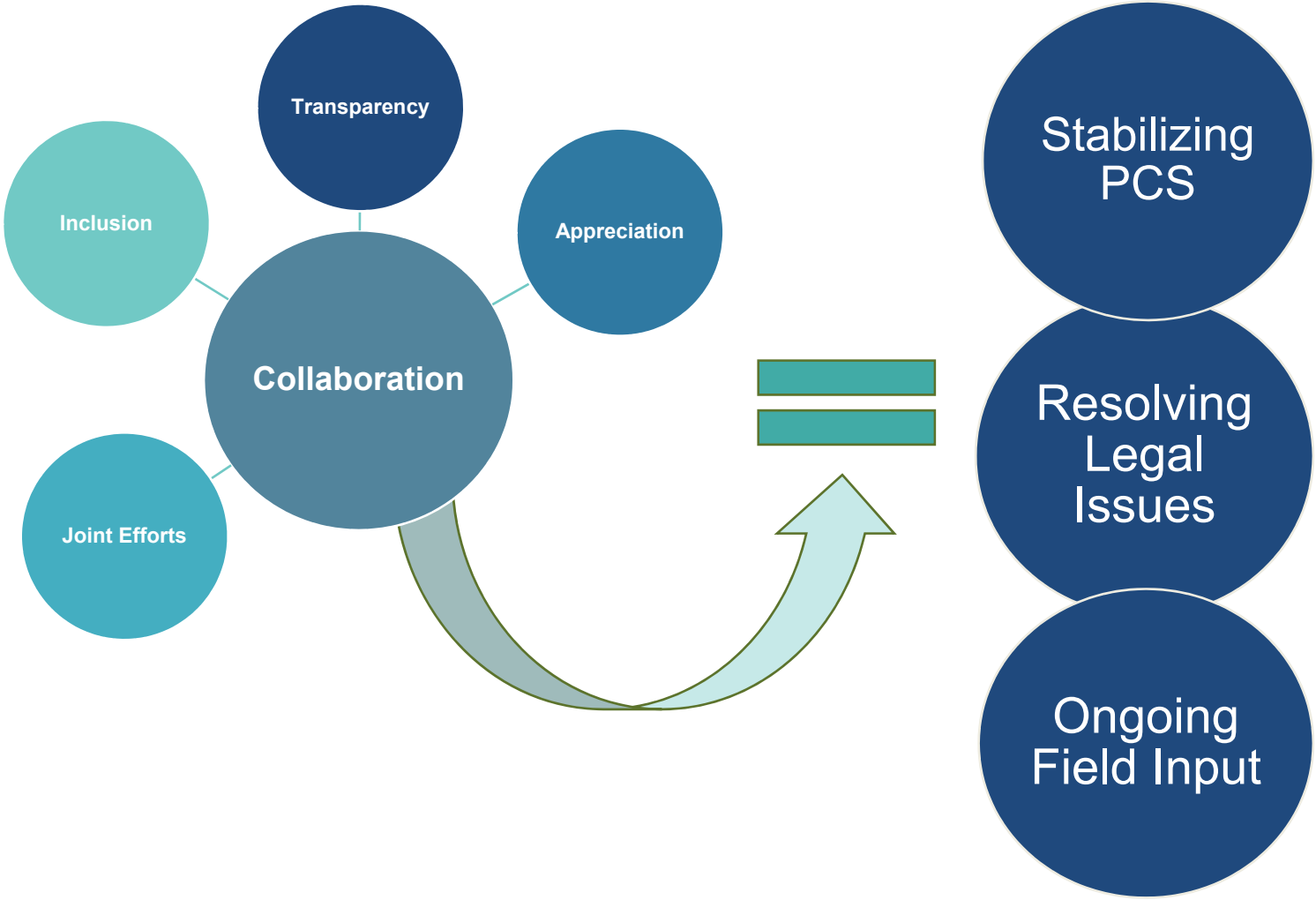
Slide 4

RL1 Rascoe, Linda, 1/23/2020

Review of Legislation

Sabrena Lea
Associate Director
Long-Term Services and Supports
Division of Health Benefits

Our Work with Stakeholders



Medicaid Overview

Sabrena Lea
Associate Director
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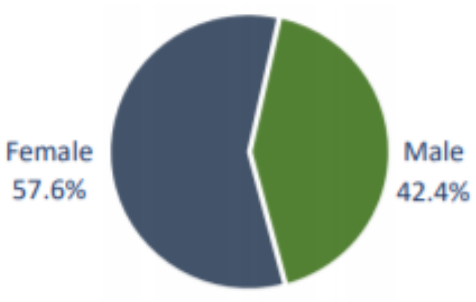
Snapshot: North Carolina Medicaid and NC Health Choice – State Fiscal Year 2019

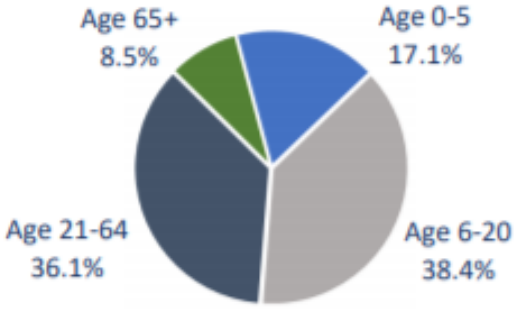
Financials ($ billion)	
Expenditures	$15.0
Federal Revenue	$ 9.7
Other Revenue	$ 1.6
State Appropriations[3]	$ 3.8

Statistics	
Medicaid Beneficiaries[1]	2.1 million
NC Health Choice Beneficiaries[1]	104 thousand
Providers[2]	71.3 thousand
Claims Processed[4]	213 million

Beneficiary Gender[5]



Beneficiary Age[5]



Long-Term Services and Supports

Array of Medicaid Funded Long-Term Services and Supports

Intermittent Clinical Services

- Home Health (non PDN)
- Hospice
- Home Infusion Therapy

Non Clinical Assistance with Activities of Daily Living

- PCS (Private Living and Congregate Residential Settings)

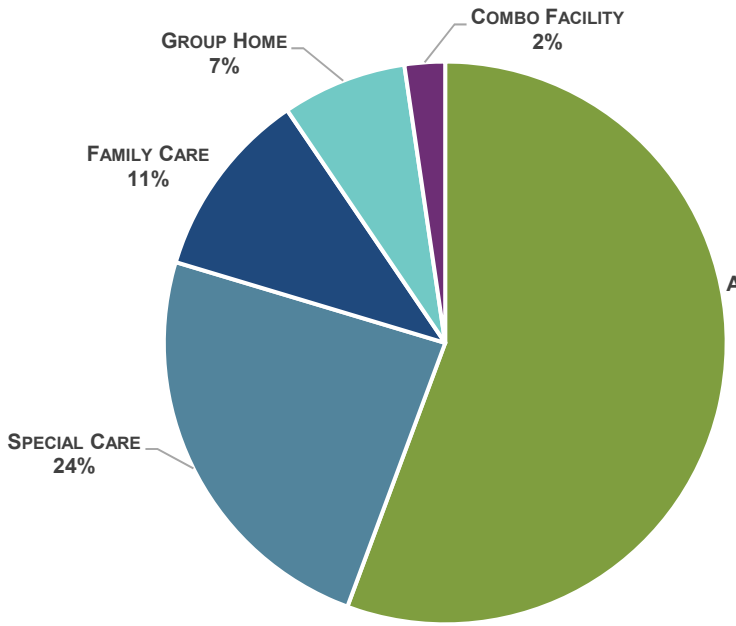
Community Based Alternative to Institutional Level of Care

- CAP Disabled Adults and Children
- PACE
- PDN (Adult and Children)

Highest Beneficiary Acuity (Institutional)

- Nursing Facilities
- Long Term Acute Care
- Gero-Psychiatric Hospitals

Total Individuals



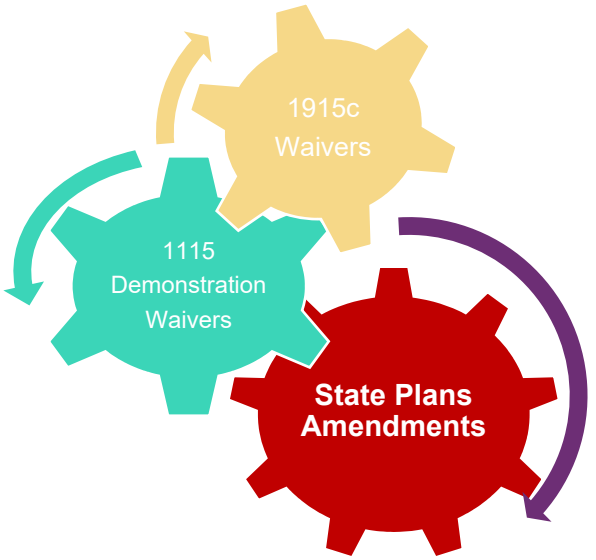
Total Individuals	11997
Adult Care Homes	6,677
Special Care	2,877
Family Care	1,304
Group Home	860
Combo Facility	279

Source: DHSR Licensed Facilities updated 1/8/2020

Medicaid Authority : State Plan Amendments (SPAs)

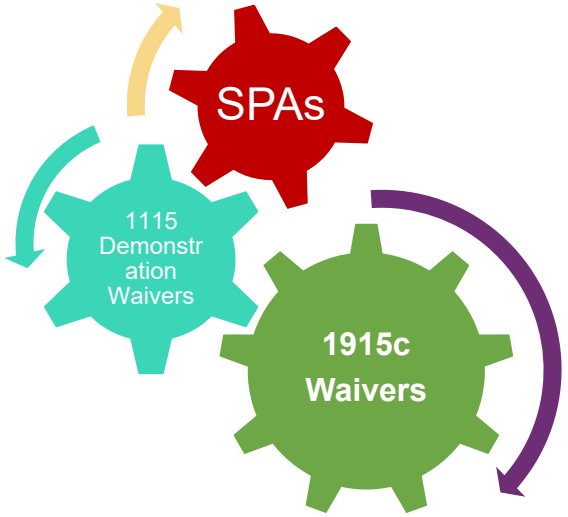
A Medicaid and CHIP **state plan** is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. State Plans define:

- Groups of individuals to be covered,
- Services to be provided,
- Methodologies for providers to be reimbursed, and
- Administrative activities



Medicaid Authority : 1915 Waivers

Home and Community Based Services (HCBS) first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving States the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State plan option. Several States include HCBS services in their Medicaid State plans. Forty seven states and DC are operating at least one 1915(c) waiver.



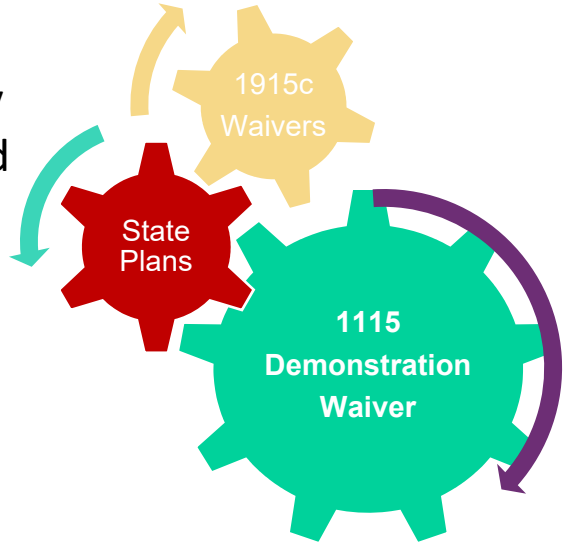
State Medicaid agencies have several HCBS options:

- 1915(c) Home and Community-Based Waivers
- 1915(i) State Plan Home and Community-Based Services
- 1915(j) Self-Directed Personal Assistance Services Under State Plan
- 1915(k) Community First Choice

Medicaid Authority : 1115 Demonstration Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

- Demonstrations offers states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to serve Medicaid populations more effectively.
- Demonstration projects present an opportunity for states to institute reforms that go beyond just routine medical care, and focus on evidence-based interventions that drive better health outcomes and quality of life improvements.



Questions

Payment Methodology

Reggie Little
Associate Director
Provider Reimbursement (FFS)
Division of Health Benefits

Rate Methodology Milestones

- **Jan. 1, 2000**
  - Cost of medication administration and PCS direct supervision added to basic fee.
  - Payments to providers were cost settled, overpayments repaid to DHB.
- **July 1, 2007**
  - An inflationary increase of 2.64% was applied to the fee schedule.
- **Oct. 1, 2009**
  - A 5.02% rate reduction (annualized over nine months) was applied to the fee schedule. There was no inflationary increase.

SOURCE: State Plan Attachment 4.19-B, Section 23, Page 6a

(cont.)

- **May 9, 2010**
  - Previous rate methodology end dated. Payments for cost reporting periods ending on/after Dec. 31, 2009 not subject to cost settlement.
- **May 10, 2010**
  - Fee schedule rates (set as of Oct. 1, 2009) are the same for both governmental and private providers of PCS in ACHs.

SOURCE: State Plan Attachment 4.19-B, Section 23, Page 6a

Historical ACH Rate Methodology

- The ACH basic fee was formerly based on 1.1 hours of service per resident day and was computed by determining:
  - Estimated salary
  - Fringes
  - Direct supervision
  - Cost of medication administration
  - Allowable overhead

SOURCE: State Plan Attachment 4.19-B, Section 23, Page 6b

(cont.)

- Rates were calculated based on a cost reporting period selected by the State. Reimbursement did not include room and board.
- The basic fees in effect prior to Jan. 1, 2013 consisted of a rate for 1-30 bed facilities and a higher rate for 31+ bed facilities.

SOURCE: State Plan Attachment 4.19-B, Section 23, Page 6a *and https://medicaid.ncdhhs.gov/providers/fee-schedules*

(cont.)

- For Medicaid-eligible residents who demonstrated a need for additional care, enhanced rates were billed in addition to the basic rate. These enhanced services included:
  - Eating
  - Toileting
  - Ambulation/Locomotion
- Additional fee schedule rates included:
  - SCU (Alzheimer's)
  - Transportation – NEMT

SOURCE: ***https://medicaid.ncdhhs.gov/providers/fee-schedules***

(cont.)

- Per NC General Assembly Session 2011, House Bill 950, DHHS must implement a new consolidated PCS benefit.
- Effective May 1, 2012, CMS approved an NC State Plan Amendment revising the scope of Personal Care Services (formerly called In-Home Care). This approval extended the sunset deadline of IHC and ACH from April 30, 2012 to Dec. 31, 2012.

SOURCE: NC General Assembly Session 2011, Session Law 2012-142, House Bill 950 *and*
NC Medicaid Special Bulletin, July 2012, Transition Planning for Implementation of Consolidated Personal Care Services

Current Rate Methodology

- Effective January 1, 2013, Medicaid Personal Care Services for recipients in all settings, including licensed adult care home facilities, would be provided under a consolidated PCS benefit.

Proc Code	Modifier	Billing Unit	Eff 1/1/13	Eff 1/1/14	Eff 8/1/17	Eff 1/1/18
99509	ALL	15 min	$3.58	$3.47	$3.88	$3.90

- ACH billed with modifier HC

SOURCE: NC Medicaid Special Bulletin, July 2012, Transition Planning for Implementation of Consolidated Personal Care Services and *https://medicaid.ncdhhs.gov/providers/fee-schedules*

Analysis of Surrounding States

State	Service Description	Hourly Rate
North Carolina	Personal Care Services (All Settings)	$15.60
South Carolina	Personal Care Services - Personal Care I (S5130) - Personal Care II (T1019)	 $14.00 $18.40
Georgia	Personal Support Service - T1019, <= 10 units (2.5hrs) - T1019 TF, >= 12 units - T1019 UC, consumer-directed	 $20.20 $17.96 $19.20
Virginia	Personal Care Services (T1019) Northern VA Rest of State	 $13.70 $16.13

Rate Sources

NC **Community Alternatives Program (CAP) Waiver**
https://medicaid.ncdhhs.gov/providers/fee-schedules

SC **Community Long Term Care Waiver**
https://www.scdhhs.gov/internet/pdf/manuals/cltc/Manual.pdf
https://www.scdhhs.gov/resource/fee-schedules **(CLTC fee schedule)**

GA **Community Care Services Program Waiver** ***http://www.georgiahealth.us/wp-content/uploads/2018/04/CCSP-General-Services-April-2018.pdf***

VA **Commonwealth Coordinated Care (CCC) Plus Waiver**
https://www.dmas.virginia.gov/#/ratesetting
https://www.dmas.virginia.gov/#/longtermwaivers

Questions

Home- and Community-Based Services Final Rule

Mya Lewis
Section Chief, IDD & TBI
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Overview of the HCB Settings Rule

- Federal Requirement
  - Federal Register Vol. 79, No. 11, January 16, 2014
- Defines and describes the requirements for home and community-based settings for 1915(c) waivers, 1915(i) State Plan, and 1915(k)
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS
- Effective Date of the Rule – March 17, 2014.

Purpose

- To ensure that individuals receiving long-term services and supports through home- and community-based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.
- To enhance the quality of HCBS and provide protections to participants.

***1915(c) is applicable to NC**

CMS Criteria Regarding Provider Sites

General HCBS Criteria

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 integrated settings, engage in community life, and control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.
   - Transportation
   - Interaction

(cont.)

2. The setting is selected from an array of options that are non-disability specific (includes private room in home).
   - 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 in which they work, etc.?

(cont.)

3. Ensures the right to 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?

(cont.)

4. Optimizes independent initiative, autonomy, choice making (daily activities, environments, interaction).
   - 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, 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 schedule, locations of the activities?

(cont.)

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 schedule, 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?
   - Does the individual have a meal at the time and place of their choosing?
   - Are snacks accessible and available at all times?

(cont.)

6. Facilitates choice regarding services, supports, and providers.
   - Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.)?
   - Do people select the provider from among an array of options?

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?

(cont.)

Residential HCBS Criteria

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?

9. Property can be rented, owned, or occupied under tenant law or there is a lease agreement with the provider for each participant.
   - Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?
   - Do people have the same responsibilities that other tenants have under landlord/tenant laws?

(cont.)

10. Units are lockable by the individual and only necessary staff have keys.
    - 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 use?

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

    Do people choose their roommates?

(cont.)

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?

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?

Heightened Scrutiny

North Carolina's Process

If a setting is:

- Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- In a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Current NC 1915(c) Impacted by HCBS

- North Carolina Innovations (Innovations)
- Community Alternatives Program for Disabled Adults (CAP/DA) the self-directed option, CAP Choice
- Community Alternatives Program for Children (CAP/C)
- NC Traumatic Brain Injury Waiver (new waiver)

Implementation Requirements

- Create a transition plan.
- Evaluate the settings and services specified in waiver programs.
- Evaluate state statutes, rules and policies for conflicts.
- Obtain public comment and input regarding the transition plan.
- Show substantial progress in meeting federal rule.
- Full compliance initially set for March 2019 must now occur no later than March 17, 2022.
- Ensure new and amended waiver(s) meet federal requirements immediately.

Person-Centered Planning

Planning must be developed through a person-centered planning process

- Directed by the individual
- Address health and long-term services and support needs
- Reflect individual preferences and goals
  - community participation
  - employment
  - health care and wellness
  - education
- Paid and unpaid

Questions

Please send all feedback to HCBSTransPlan@dhhs.nc.gov

Care & Quality Strategy

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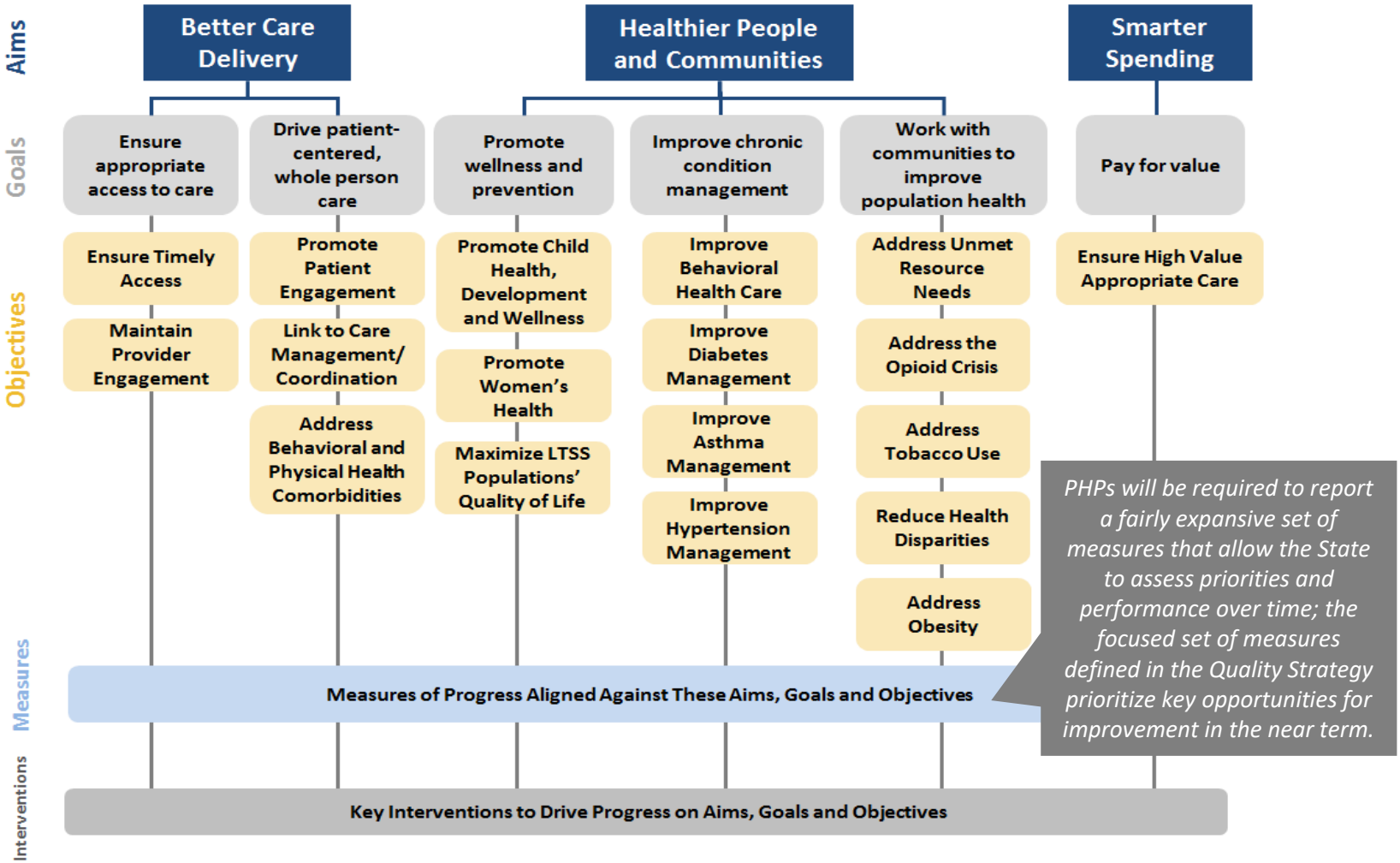
Quality Governance

State Medicaid Managed Care Quality Strategy

States are required to implement a Quality Strategy to assess and improve the quality of managed care services offered within the state.

The Quality Strategy is "intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care beneficiaries receive, as well as for setting forth measurable goals and targets for improvement" (Medicaid.gov)

Overview of the Quality Framework



Interventions and Objectives

Figure 5. Linking Interventions to Objectives

Intervention	1.1: Timely access to care	1.2: Provider Engagement	2.1: Patient engagement	2.2: Care mgmt. & coordination	2.3: Coordinated physical & BH care	3.1: Child health, development, & wellness	3.2: Women's health	3.3: LTSS quality of life	4.1: Behavioral health care	4.2: Diabetes management	4.3: Asthma management	4.4: Hypertension management	5.1: Unmet resource needs	5.2: Opioid crisis	5.3: Tobacco use	5.4: Reduce health disparities	5.5: Obesity	6.1: High value care
(1) Opioid Strategy		◆			◆				◆				◆	◆				◆
(2) Social Determinants of Health Strategy	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
(3) Advanced Medical Homes (AMHs)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆
(4) Care Management for High-Risk Pregnancy	◆	◆	◆	◆	◆	◆	◆											◆
(5) Care Management for At-Risk Children			◆	◆		◆							◆			◆		◆
(6) Behavioral Health Integration	◆	◆		◆	◆		◆		◆				◆					
(7) Provider Supports		◆		◆	◆								◆					◆
(8) Workforce	◆	◆														◆		
(9) Telemedicine	◆	◆	◆													◆		◆
(10) Value-Based Payment (VBP)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
(11) Centers for Disease Control and Prevention (CDC) 6|18 Initiative							◆			◆					◆			◆
(12) Accreditation	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆
(13) Disparities Reporting & Tracking	◆												◆			◆		

Summary – Primary Performance Levers

1. **Quality Measure Reporting**
2. **Quality Baselining, Benchmarking, and Performance Target Development**
3. **Disparities Reporting and Tracking**
4. **Quality Assessment and Performance Improvement Programs (QAPIs)**
   - PHPs must develop a QAPI aligned to NC DHHS goals, and annually approved by NC DHHS
   - Key components include internal-to-PHP processes for monitoring and correcting performance, conducting performance improvement projects, and addressing disparities in care
5. **Value-Based Payment/Provider Incentives**
   - PHPs are required to develop a provider incentive program for Advanced Medical Home (AMH) providers; incentives must be based on AMH quality measure list (a subset of the measures used for Quality reporting)
   - PHPs are given flexibility to develop provider incentives – a tool for: (1) meeting NC DHHS-set minimums for payments attributed to alternative payment models; and (2) meeting NC DHHS-set quality targets
6. **External Quality Assurance Validation**
   - Accountability for quality performance is layered into accreditation requirements. The External Quality Review Organization (EQRO) will validate PHP measure reporting and validate PHP contract compliance.

Quality Measurement and Reporting

NC Medicaid Quality Measurement Approach

Quality Vision for Medicaid Transformation

1. Robust measure set and measure reporting that allow NC to track progress against quality priorities at a stratified level
2. Accountability for quality from Day 1
3. Immediate attention to maintaining and improving current measures of care, promoting health equity, and being transparent with quality results.

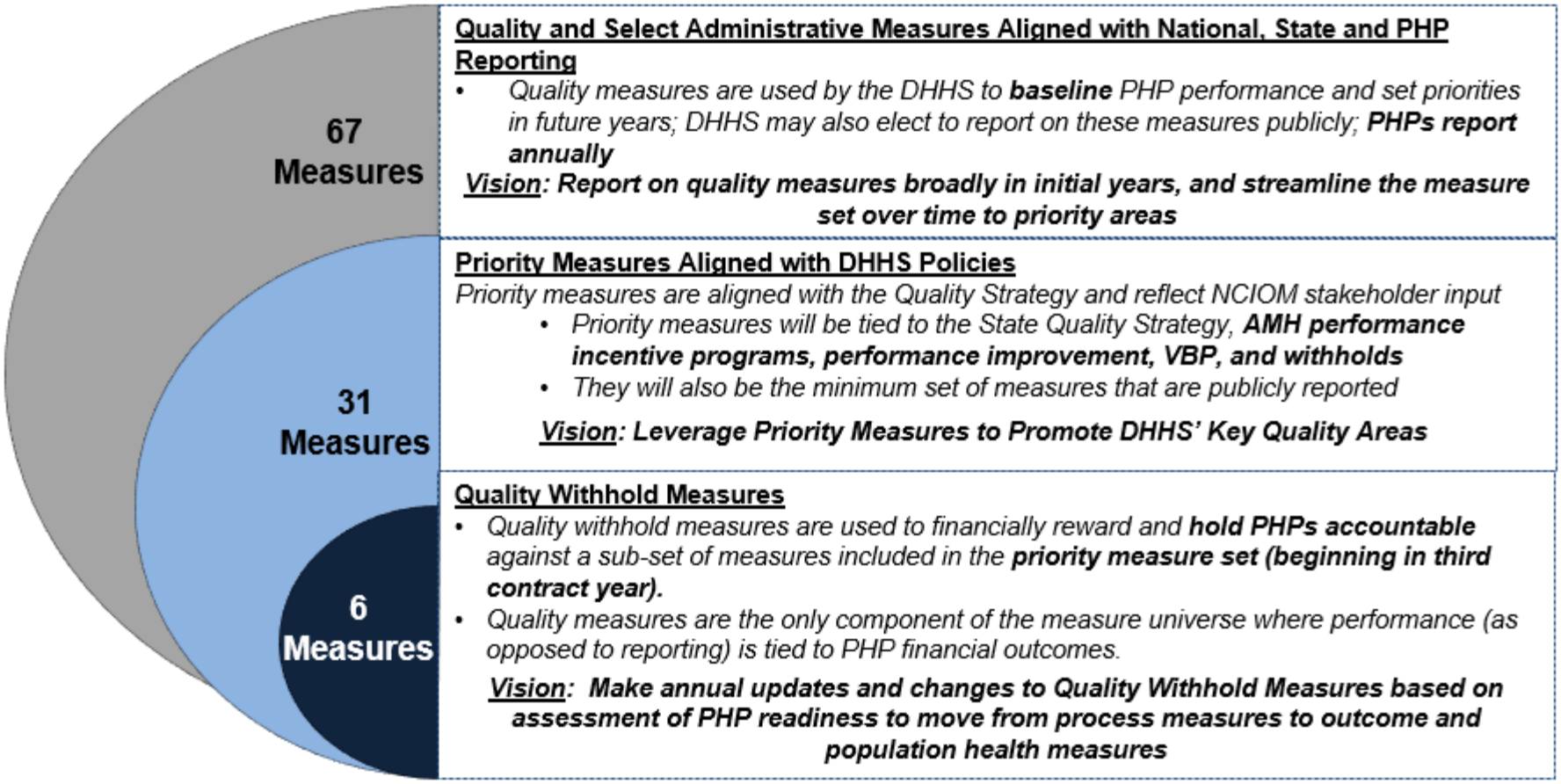
Other Factors Shaping Quality Approach

- DHHS expects providers will require time to update documentation and coding processes for managed care environment
- Public health priorities (particularly low birth weight) require new approach for managed care

Note: Legislative requirements prevent the use of withholds until Contract Year 3.

Overview: NC Medicaid Quality Measures

PHPs will be required to report on a robust measure set, but must focus on narrower subset of measures reflecting DHHS priorities in contracting with providers. DHHS expects PHPs will incorporate these measures into their contracting and other engagement with practices.



For a full list of quality measures, please see here.

Assessment of PHP Performance on Quality Measures

- Historical **baselines** for all measures
- **Benchmarks** representing optimal performance levels
  - Aspirational
  - Identify high-performing PHPs
  - Support PHPs' quality improvement efforts
  - NOT linked to financial accountability
- Use Quality Compass HEDIS **national percentiles** for targets

Measure Name	2016 Rate	2017 Rate	National Comparison	NC Target
Goal 1: Ensure Appropriate Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
12 - 24 months of age	96.01%	96.46%	🟡	75th
25 months - 6 years old	88.40%	88.75%	🟡	75th
7- 11 years old	91.44%	91.51%	🟡	75th
12- 19 years old	88.18%	88.31%	🟡	50th
Getting Care Quickly	*N/A*	*84.22%*	🟢	*75th*
Getting Needed Care	*N/A*	*82.99%*	🟡	*50th*
Rating of Health Plan	N/A	70.76%	🔴	50th

Future Uses of Quality Withholds and Overall Quality Results

Beginning July 1, 2021, DHHS will measure PHPs' performance against select withhold measures, for which PHPs will be financially accountable.

Select Withhold Measures

- Drawn from Priority Measure set
- Targets will be calculated representing levels required to receive some/all quality withhold
- Concise set of goals to move toward outcome measures

Initial Withhold Measures

- Prenatal/postpartum care
- Live births <2,500 grams
- Well-child visits in years 3-4-5-6
- Comprehensive diabetes care: HbA1c Poor Control (>9.0%)
- Follow-up after emergency visit for mental illness, alcohol or other drug abuse
- Initiation engagement of alcohol and other drug dependence treatment

Stratified Reporting

Ensure Improvements in Quality Performance Maintain or Promote Health Equity

Stratification Element	Strata*	Source
Age	For pediatric measures: 0-1, 2-3, 4-6, 7-10, 11-14, 15-18 For maternal health:<19, 19-20, 21, 22-24, 25-34, 35+ For adult/full pop. measures: 0-18, 19-20, 21, 22-44, 45-64, 65+	DHHS enrollment data
Race/ethnicity	Hispanic, Non-Hispanic Black, Non-Hispanic White, American-Indian/Alaska Native, Asian/Pacific Islander, Other	DHHS enrollment data (self-reported where possible)
Gender	Male, Female, Third Gender (Other)	DHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	DHHS enrollment data (self-reported where possible)
LTSS Needs Status	Yes, No	TBD
Disability Status	Disability, No disability	DHHS enrollment data
Geography	Rural, urban	DHHS enrollment data
Service Region	1-6	DHHS enrollment data

**If a measure's specifications include stratification for any of the above elements, that stratification will supersede the stratifications listed above.*

Quality Assurance & Quality Improvement

Quality Assurance

- EQRO: DHB will procure (federally required) External Quality Review Organization (EQRO) to assess the quality of care provided by PHPs
- Accreditation: PHPs are required to achieve NCQA Health Plan Accreditation by Year 3

Quality Improvement

- QAPI: PHP must develop an annual Quality Assessment and Performance Improvement (QAPI) program for measure areas that need improvement.
- PIPs: PHPs must have targeted clinical/non-clinical Performance Improvement Projects (PIPs) each year.

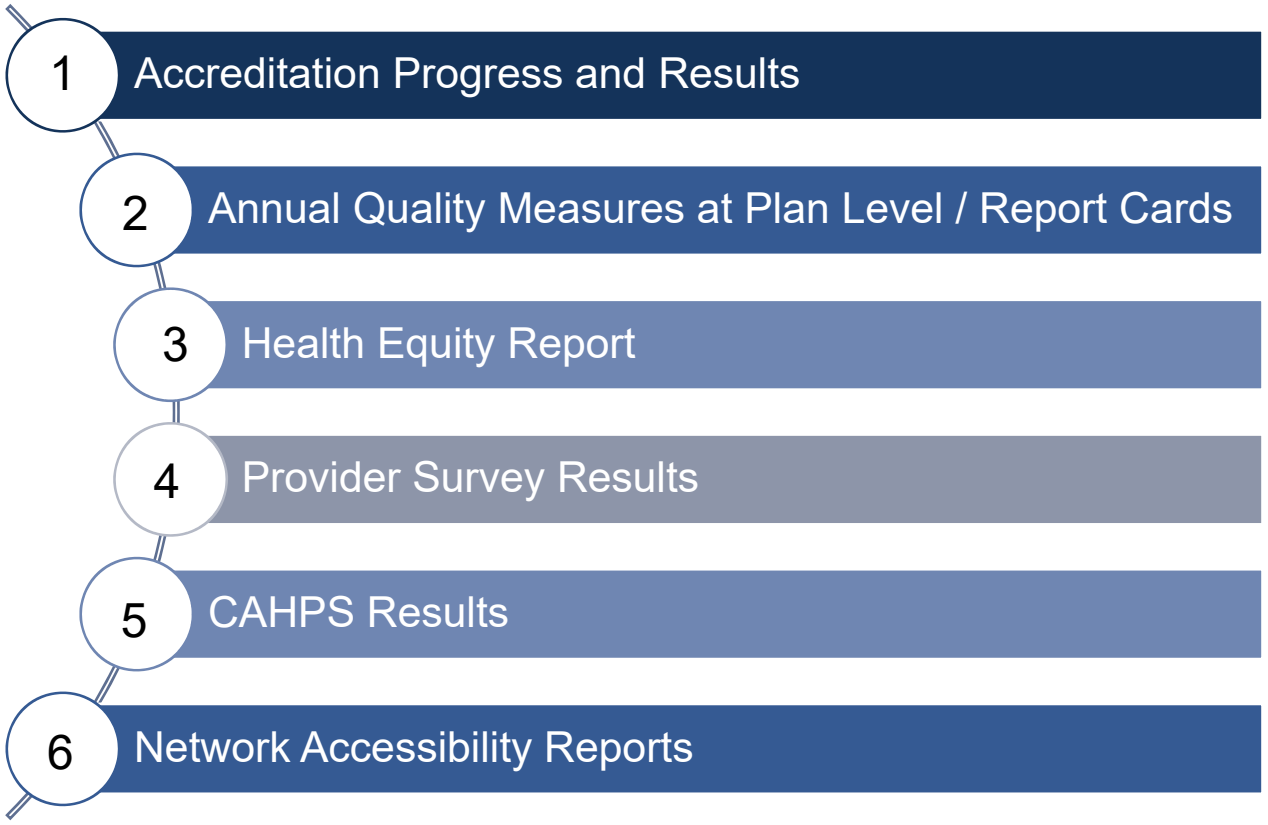
NCQA Measures for LTSS Distinction

- LTSS Comprehensive Assessment and Update
- LTSS Comprehensive Care Plan and Update
- LTSS Shared Care Plan with Primary Care Practitioner
- LTSS Re-assessment/Care Plan Update after Discharge

Measure specifications available for free

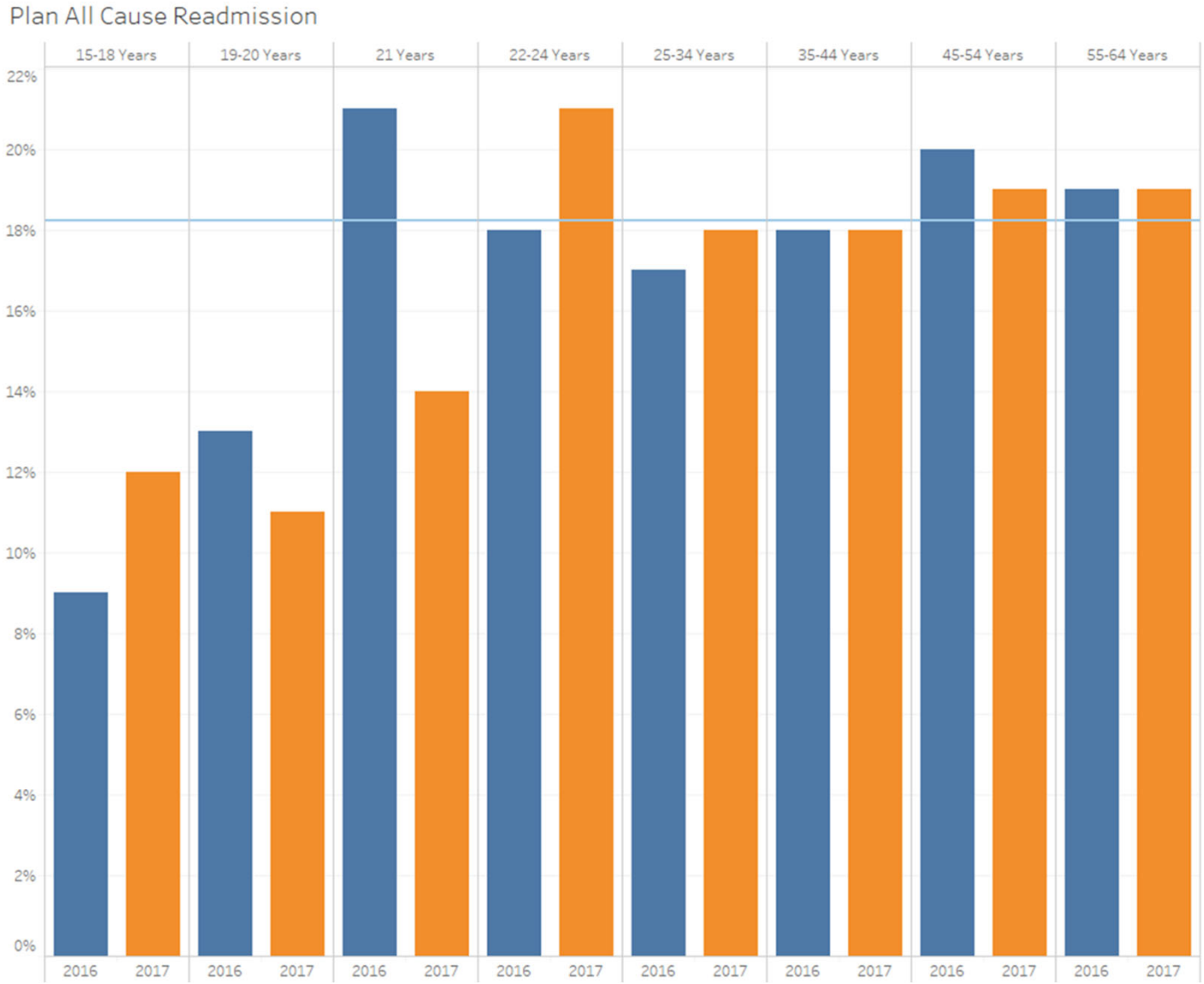
http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2020-technical-specifications-for-ltss-organizations-epub/

Quality: Public Reporting of Performance

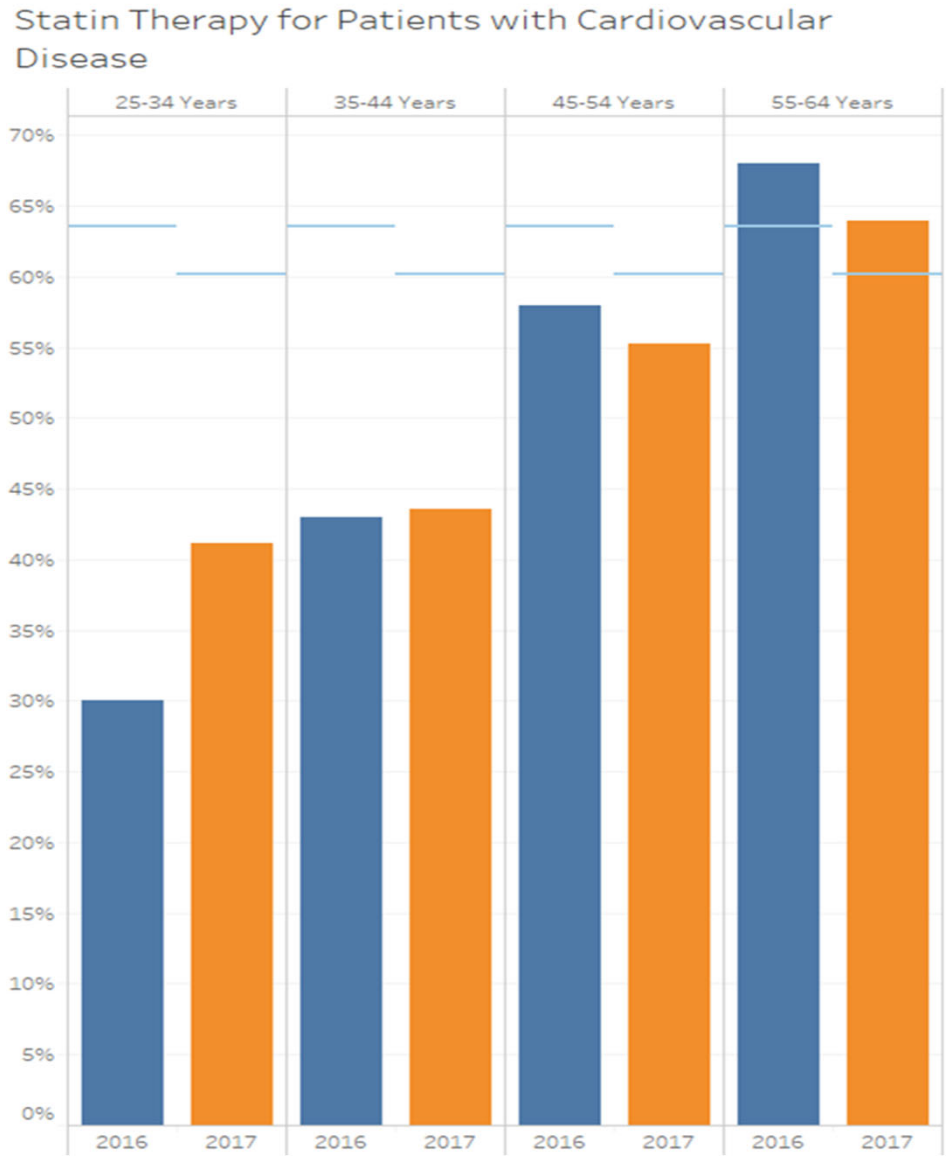


HbA1c Testing by Age Group

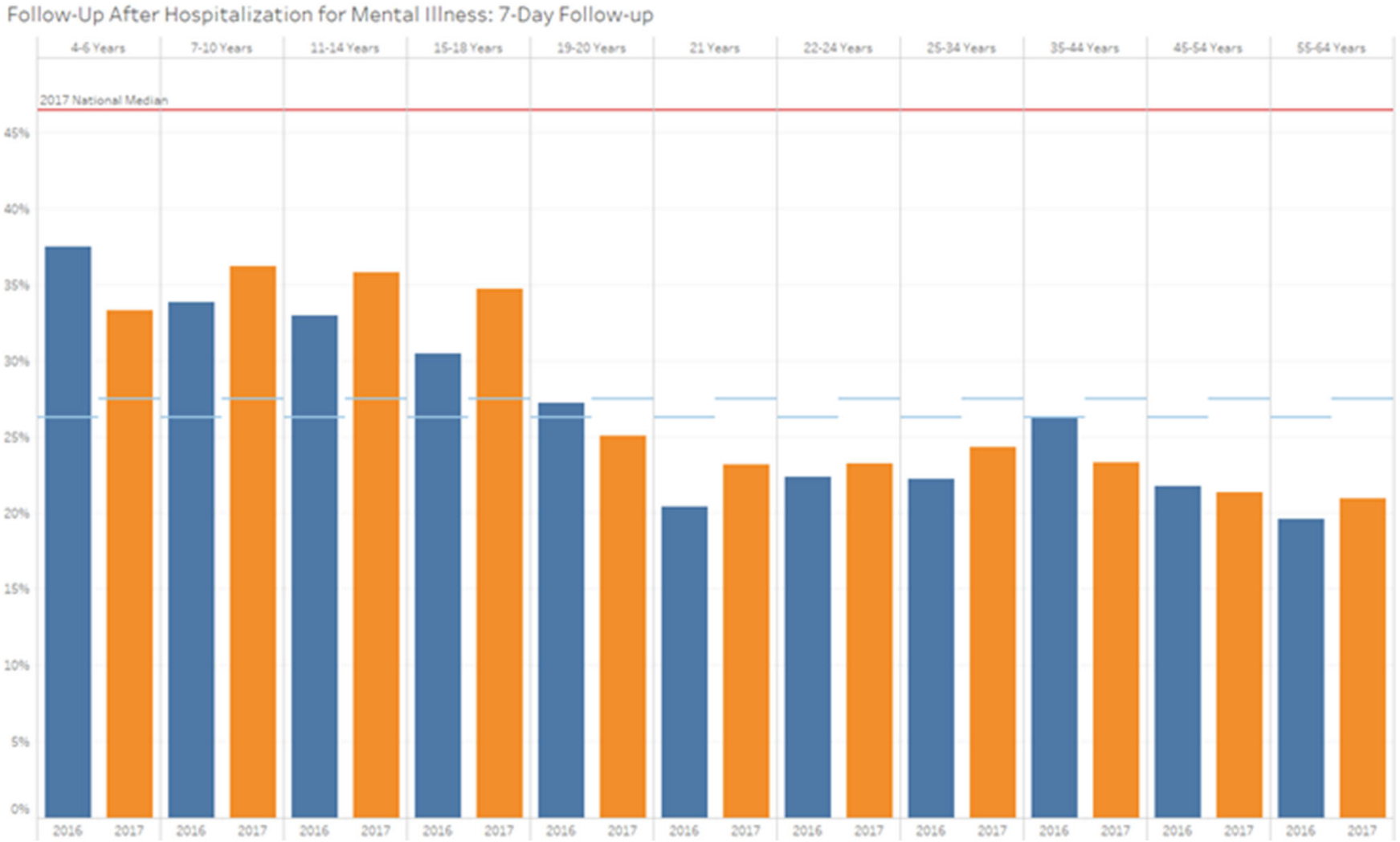
Plan All Cause Readmission



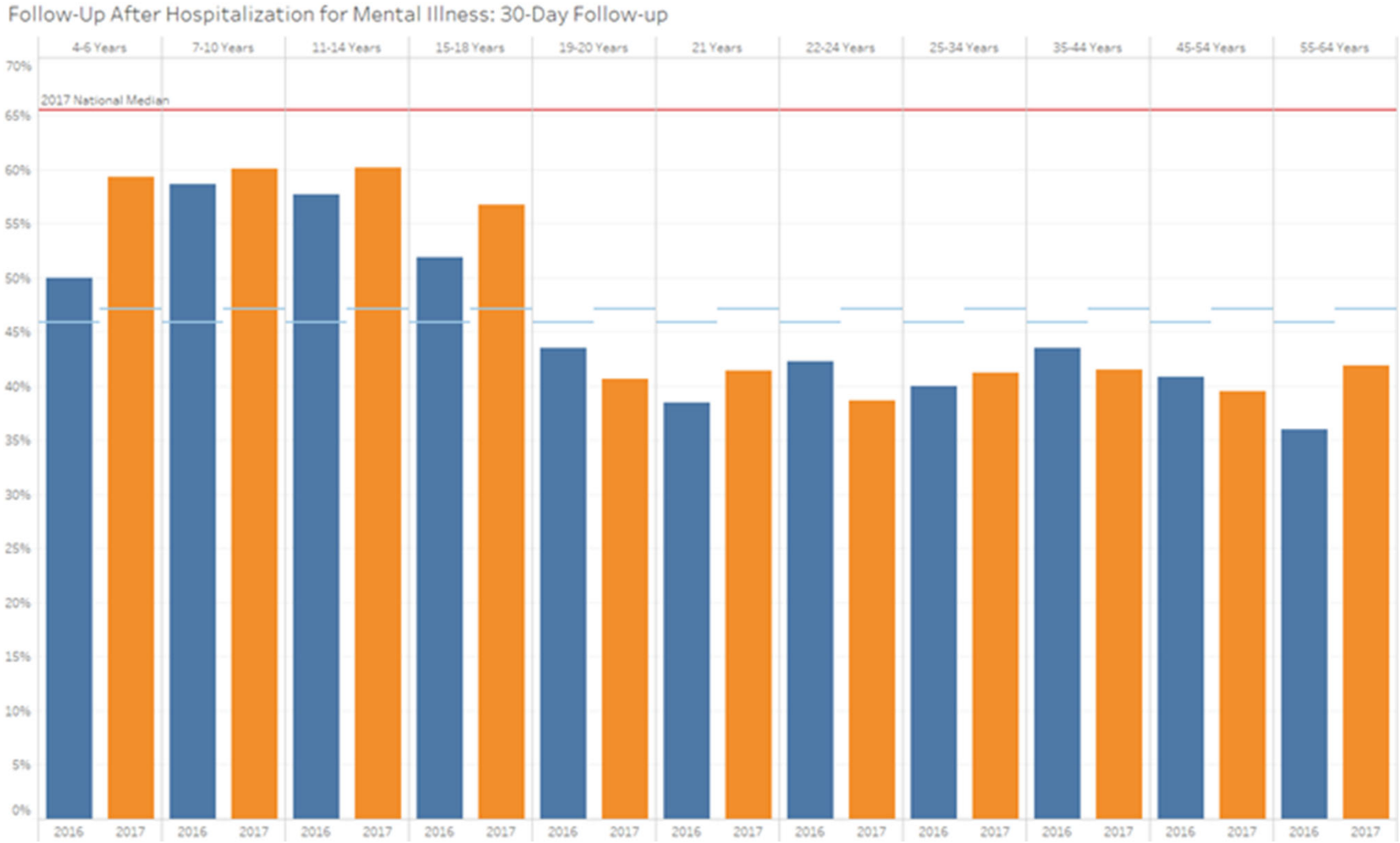
Statin Therapy for Cardiovascular Disease



Follow-Up After Emergency Visits for Mental Illness, Alcohol/Drug Abuse (7 Days)



Follow-Up After Emergency Visits for Mental Illness, Alcohol/Drug Abuse (30 Days)



Resources

Medicaid Quality Management and Improvement
https://medicaid.ncdhhs.gov/quality-management-and-improvement

Kelly.Crosbie@dhhs.nc.gov
Deputy Director, Quality and Population Health

Jaimica.Wilkins@dhhs.nc.gov
Senior Program Manager, Quality Management

Sam.Thompson@dhhs.nc.gov
Senior Program Manager, Program Evaluation

Questions

Regulatory Overview

Megan Lamphere, Chief
Adult Care Licensure Section
Division of Health Service Regulation

Defining Adult Care in N.C.

Adult Care Homes (7+ beds)

Special Licensure Designations (optional)

- **Serving only elderly (55 and older)**
- **Special Care Unit for Alzheimer's/Dementia**

Family Care Homes (2-6 beds)

Multi-Unit Assisted Housing with Services

Licensed Combination Facilities – licensed nursing homes with adult care home beds, regulated by the DHSR Nursing Home Licensure & Certification Section.

Regulation of Adult Care Homes in N.C.

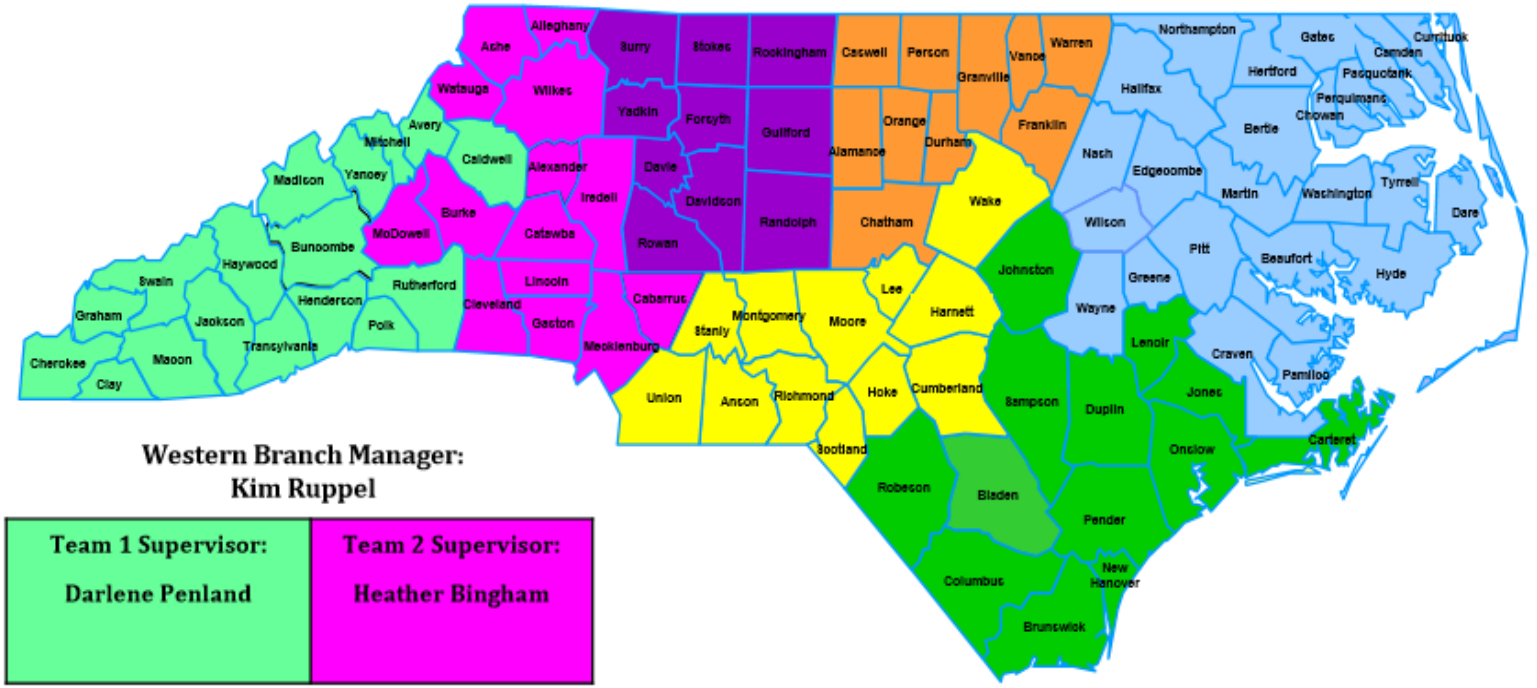
Division of Health Service Regulation (DHSR)

- **Adult Care Licensure Section**
  - Licenses and inspects ACH/FCHs (annual or biennial surveys)
    - Surveys include annuals/biennials, follow-up, complaints, initials
  - Issues administrative licensure actions
  - Imposes civil monetary penalties
  - Administers Star Rating and Administrator Certification Programs
- **Construction Section**
  - Approves initial building plan and design
  - Biennial inspections of physical plant and life safety

County Departments of Social Services

- Routine monitoring (at least quarterly)
- Complaint investigations

Adult Care Licensure Regions



Western Branch Manager:
Kim Ruppel

Team 1 Supervisor:	Team 2 Supervisor:
Darlene Penland	Heather Bingham

Central Branch Manager:
Eva Oakley

Team 3 Supervisor:	Team 4 Supervisor:
Carolyn Harrison	Bridget Rackley

Eastern Branch Manager:
Dai Tworek

Team 5 Supervisor:	Team 6 Supervisor:	Team 7 Supervisor:
Suzy Morgan	Tamara Talbot	Theresa Conley

Regulatory Requirements

Statutory Authority: N.C.G.S. 131D

Rulemaking Authority: N.C. Medical Care Commission, DHHS Secretary

10A NCAC 13F Rules for Adult Care Homes 7+ Beds

10A NCAC 13G Rules for Family Care Homes 2-6 Beds

Licensing
Staff Qualifications & Training
Resident Assessment & Care Plans
Residents' Rights, Care & Services
Management of Residents' Funds
Policies, Records and Reporting
N.C. Star Rated Certificate Program

Physical Plant/Environment
Admission & Discharge
Medication Administration
Use of Physical Restraints
Staffing
Administrator Certification/Renewal

Licensing Process

- Certificate of Need (for ACHs)
- Local zoning approval
- DHSR Construction review and approval
- Licensure review and approval
    - Approved administrator
    - Compliance history review
    - Policy and procedure review
    - Pre-licensing visit by ACLS
- Annual license renewal

Services Provided in Adult Care Homes

- Assistance with ADLs
- Supervision
- Medication Administration
- Transportation
- Activity Programming
- Dining and Nutrition Services
- Referral to Medical Providers/Health Professionals
- Housekeeping & Laundry
- Maintenance
- Assessment & Care Planning
- Referrals for Care & Services
- Personal Funds Management

Services Not to be Provided in N.C. Adult Care Homes

- Individuals cannot be admitted:
  - For treatment of mental illness, or alcohol or drug abuse;
  - For maternity care;
  - For professional nursing care under continuous medical supervision;
  - If the individual is ventilator dependent;
  - For lodging, when the personal assistance and supervision offered for the aged and disabled are not needed;
  - Who pose a direct threat to the health or safety of others; or
  - If the individual needs cannot be met in the facility as determined by the facility.

Resident Population

	Adult Care Homes	Family Care Homes
# Licensed Beds	36,289	3,259
% Occupied Beds	72.75%	83.22%
# Licensed Special Care Units (SCU)	246	N/A
# Licensed SCU Beds	8599	N/A
% Occupied SCU Beds	77.8%	N/A
Residents by Diagnosis		
% ALZ/Dementia	43%	22%
% I/DD	4%	14%
% Mental Illness	11%	45%

Data obtained from 2019 license renewal applications.

Resources

DHSR Adult Care Licensure Website

https://info.ncdhhs.gov/dhsr/acls/index.html

ACH & FCH General Statutes & Rules

https://info.ncdhhs.gov/dhsr/acls/rules.html

Adult Care Home Inspections, Star Ratings & Penalties

https://info.ncdhhs.gov/dhsr/acls/star/search.asp

DHSR ACLS Staff Contacts

https://info.ncdhhs.gov/dhsr/acls/adultcarestaff.html

Questions

Small Group Discussion

ACH Stakeholder Discussion Questions:

1. **What other information is there that was NOT presented today to inform our thoughts and ideas?**

2. **Based on what you have heard today, what questions are raised?**

3. **Anyone else we need at the table to help inform this decision?**

4. **What can we do to ensure that in this process we have the opportunity to hear from Medicaid beneficiaries who are living this experience?**

Report Out & Next Steps