Question	Category	Response
Where is the electronic information posted regarding the HCBS final rule?	HCBS Final Rule	The HCBS final rule published by CMS can be found at the following link: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider
Does the HCBS federal mandate cover services like (b)(3) services and mental health supported employment services?	HCBS Final Rule	The HCBS rule applies to all services and supports rendered under the 1915(c) waiver for North Carolina. This does include (b)(3) supported employment, including mental health supported employment services.
If there are sites that offer multiple services (e.g. day supports and supported employment), do they have to get validated once or for each service?	Multiple Services	Although a site requires one source of validation, if multiple types of services are provided, consideration should be taken to ensure that all services provided at the site are being validated. It is noted that the same tools could be used to validate both services listed in the HCBS database. For example, if it is a day support and corporate supported employment site, a Care Coordination Tool may be used to validate the day support service; however, a SE corporate site requires a desk review or intense onsite review. Therefore, to validate the site, both tools would be used and reported on the quarterly validation reporting tool.
If a provider has more than one service at the same site that requires the Validation Process, do we need to perform the process on all services that meet the criteria every year or just one of them? If only one service needs to be validated, which service takes precedence?	Multiple Services	Although a site requires one source of validation, if multiple types of services are provided, consideration should be taken to ensure that all services provided at the site are being validated. It is noted that the same tools could be used to validate both services listed in the HCBS database. For example, if it is a day support and corporate supported employment site, a Care Coordination Tool may be used to validate the day support service; however, a SE corporate site requires a desk review or intense onsite review. Therefore, to validate the site, both tools would be used and reported on the quarterly validation reporting tool.
If a provider has more than one service at the same site that requires the Validation Process, but only provides one of these services per year should the process still be performed on all services regardless of delivery that year or only the services that are rendered?	Multiple Services	Although a site requires one source of validation, if multiple types of services are provided, consideration should be taken to ensure that all services provided at the site are being validated. It is noted that the same tools could be used to validate both services listed in the HCBS database. For example, if it is a day support and corporate supported employment site, a Care Coordination Tool may be used to validate the day support service; however, a SE corporate site requires a desk review or intense onsite review. Therefore, to validate the site, both tools would be used and reported on the quarterly validation reporting tool.
Can the sample of the My Individual Experience Survey be utilized for the on-site validation process?	My Individual Experience Survey	The My Individual Experience Survey can be used in conjunction with HCBS Care Coordination Monitoring Tab, but cannot be used as sole validation method.
What surveys would be applicable for this validation process as it related to the provider self-assessments?	My Individual Experience Survey	The LME-MCO and CAP/DA staff will no longer be required to pull applicable My Individual Experience Survey . DHHS will review My Individual Experience Surveys within the time period of January 1, 2018 – January 1, 2019 and extend the review period at each quarter until March 1, 2020.
Do all five of the specific 5 characteristics [threshold questions] have to be deficit on the My Individual Experience survey for follow-up to occur?	My Individual Experience Survey	In the event that any questions on the My Individual Experience Survey are answered adversely, it is recommended that follow up occur to support the identified site to meet HCBS compliance. DHHS will be reviewing My Individual Experience Surveys for negative responses as a part of the validation process and reporting findings to LME-MCO/CAP-DA staff.
Are the LME-MCOs responsible for reporting My Individual Experience Survey data?	My Individual Experience Survey	Effective April 1, 2019, LME-MCOs/CAP-DA are no longer responsible for reporting My Individual Experience Survey data.
How can Care Coordinators complete face to face My Individual Experience surveys?	My Individual Experience Survey	The Care Coordinator can assist with My Individual Experience Survey by printing the online survey and completing with the beneficiary in person.
What about sites that submitted provider self-assessments but not providing any current services? Are they to be counted for the validation process?	Provider Self-Assessment	Sites that are not in an active status, meaning they are no longer contracted with LME-MCO and not providing services should be noted as "not accepted" in the database with a notation of why. If a site is contracted with a LME-MCO and not providing services, the site should be validated using a desk review or intense onsite review.
What is the “Assessment Number” on the Validation Tool?	Provider Self-Assessment	It is the unique identifying number for each Provider Self-Assessment assigned by the system. The assessment number is located on the Provider Self-Assessment in the Demographic section listed under ID.
Since PHI is an issue, could the provider assessment's assigned number be used for tracking purposes?	Provider Self-Assessment	PHI should not be included in provider self-assessments. LME-MCOs/CAP-DA may use the provider self-assessment number for tracking purposes.
What happens when staff (QP) is no longer with an agency therefore when questions are pending the request isn’t going through successfully because the staff is no longer with agency?	Provider Self-Assessment	LME-MCOs are able to request via Master Index an updated name and contact information for provider's staff change.

Is a new assessment required when a provider is acquired, but has the exact same policies and procedures under the old provider?	Provider Self-Assessment	Yes, since the LME-MCO/CAP-DA and DHHS may not be aware of that information, this is required. The old assessment should be marked "not accept" and a note regarding the acquisition should be noted with the new assessment number to reference. In the new assessment, a comment can be added that speaks to the old assessment number for historical information. LME-MCOs/CAP-DA have been provided an HCBS Standard Operation Procedures Manual that references this process.
What happens when a site changes provider?	Provider Self-Assessment	Since the LME-MCO/CAP-DA and DHHS may not be aware of that information, a new assessment is required. The old assessment should be marked "not accept" and a note regarding the acquisition should be noted with the new assessment number to reference. In the new assessment, a comment can be added that speaks to the old assessment number for historical information. LME-MCOs/CAP-DA have been provided an HCBS Standard Operation Procedures Manual that references this process.
What happens when a provider is only contracted with another LME-MCO's catchment area?	Provider Self-Assessment	The contracted LME-MCO will be responsible for validating the site. If more than one contracted provider, DHHS will provide technical assistance.
Would a new provider self-assessment be required for an unlicensed AFL that switch to a new provider?	Provider Self-Assessment	Since the LME-MCO/CAP-DA and DHHS may not be aware of that information, this is required. The old assessment should be marked "not accept" and a note regarding the acquisition should be noted with the new assessment number to reference. In the new assessment, a comment can be added that speaks to the old assessment number for historical information. LME-MCOs/CAP-DA have been provided an HCBS Standard Operation Procedures Manual that references this process.
Should the LME-MCO contact DHHS during intense on site review or care coordinator site review if it is observed that the provider is not meeting threshold on the provider self-assessment?	Provider Self-Assessment	LME-MCOs and CAP-DA should continue existing remediation and technical assistance to providers that need support to meet HCBS compliance. If there is a concern that the provider is unwilling to comply with the HCBS final rule, then DHHS should be contacted for technical assistance. All sites must be validated by March 31, 2020.
Does the LME-MCO need to change assessment status to full integrated/fully compliant in the HCBS database?	Provider Self-Assessment	Sites are unable to be validated until they have been deemed full integration/fully compliant within the HCBS database. LME-MCOs are required to mark sites as fully compliant prior to validating within the database once they have met the criteria.
What happens if a site is not scored 100% HCBS compliance after the desk review or intense onsite review?	Provider Self-Assessment	The site would go into remediation.
How does a LME-MCO determine how many sites are fully integrated/fully compliant in their catchment area?	Provider Self-Assessment	The assessments can be sorted by fully compliant in the HCBS database to determine how many sites are full integration/fully compliant.
How does the LME-MCOs establish inter-rater reliability amongst providers in remediation?	Provider Self-Assessment	The LME-MCO is responsible for creating internal processes for providing technical assistance to providers, inclusive of establishing timelines for remediation efforts. Remediation determination should be based on each individual provider site. DHHS is available to provide technical assistance to the LME-MCO.
Should the LME-MCOs select "not accepted" during the validation process, if a site deemed full integrated is determined to need remediation?	Provider Self-Assessment	A site deemed full integration/fully compliant should be selected as "not accepted" when remediation is required during the validation process. Once the site reaches full compliance again, the assessment should be updated.
What type of communication will providers receive once they are validated?	Provider Self-Assessment	DHHS will provide template language to issue to providers on their letterhead. This will be posted to the DHHS HCBS website.
Are provider self-assessments required for sites that provide foster care to CAP-C beneficiaries?	Provider Self-Assessment	Foster care settings will not need to provide a provider self-assessment unless the setting or location is receiving a residential service under a 1915(c) waiver. NC continues to presume that individual homes are presumed to meet HCBS final rule.
Are the LME-MCOs responsible for validating or "not accepting" new SE assessments submitted in the HCBS database?	Provider Self-Assessment	Beneficiaries receiving supported employment on the waiver (Innovations and (b)(3)) should be in competitive, integrated employment, therefore the LME-MCO staff may select "not accepted" for the new Supported Employment (SE) assessments with an explanation in the comments section or the LME-MCO may choose to validate the new SE site.
What is the validation process for an AFL that no longer wishes to provide Innovation waiver services, but the provider is still contracted with the LME-MCO?	Provider Self-Assessment	The provider self-assessment for that site should be marked as "not accepted" in the HCBS database with an explanation in the comments section that details that the site no longer wishes to provide waiver services.
Can a site be marked "not accepted" during the ongoing monitoring phase when a provider fails to meet remediation requirements?	Provider Self-Assessment	The LME-MCO/CAP-DA should follow existing protocols for providers that are unwilling/unable to adhere to contract requirements after the site has been validated. DHHS should be notified through HCBSTransPlan@dhhs.nc.gov. No additional changes are needed in the HCBS database at this time.

If an Unlicensed AFL site is in your catchment area, but contracted with another LME-MCO, who is responsible for the HCBS self-assessment?	Provider Self-Assessment	The location of a site dictates which LME-MCO is responsible for reviewing and validating the site unless that LME-MCO is not contracted with that site. If an LME-MCO receives an assessment and the site is within LME-MCO-1's catchment area and: •IS contracted with LME-MCO-1 (regardless of contracts with other LME-MCOs), LME-MCO-1 is responsible for reviewing the site's provider self-assessment, validation (if applicable), and ongoing monitoring for the site. •IS NOT contracted with LME-MCO-1, the LME-MCO that is contracted with that provider is expected to review the site's provider self-assessment, validation (if applicable), and ongoing monitoring for the site. Validation is not required for sites that entered provider self-assessment January 1, 2019 or later. All new providers submitting assessments should be in compliance prior to starting services; therefore they would not be part of the transition plan and validation process.
An Employer of Record is able to self-direct Supported Employment. What is the rule concerning completion of an HCBS assessment?	Provider Self-Assessment	Employer of Record for Supported Employment sites are not required to submit an HCBS Provider Self-Assessment. Care Coordination monitoring should ensure services are provided in an integrated setting and meet HCBS requirements.
Does a note need to be added into the self-assessment when it's been identified as an erroneous or duplicate assessment to be deleted?	Provider Self-Assessment	No, a note would not need to be entered into the self-assessment if it's identified as the erroneous or duplicate record to be deleted. Duplicate assessments to be deleted should be requested on the HCBS Validation Quarterly Reporting Tool or Master Index Request.
If the site review is based upon the site and not the beneficiary, what if one or more of the beneficiaries does not have a key? Is the entire site out of compliance?	Residential	In the event of any type of rights restriction, such information should be thoroughly documented within the beneficiary's ISP. It may not be appropriate for all beneficiaries to receive a key to the home. Therefore, the provider's policies and procedures should align with HCBS compliance in how such concerns would be addressed for each beneficiary.
During validation, how should the Care Coordinator gauge AFLs who normally don't have lockable doors?	Residential	The beneficiary should have the ability to lock and unlock doors, according to the CMS HCBS Final Rule. Having lockable doors is a requirement of the CMS HCBS Final Rule. Any restrictions of rights should be noted in the beneficiary's person centered plan.
Can the guardian refuse the right for keys if a beneficiary is determined to be incompetent?	Residential	A legal guardian does have to ability to make such decisions. However, any restrictions of rights should be documented in the beneficiary's person centered plan and reviewed by appropriate parties. The LME-MCO/CAP-DA staff are able to provide technical assistance to
Does "having a key" refer to children and adults who reside in a group home or AFL?	Residential	It refers to adults living in the home.
If a group home or AFL has an alarm system, will the home be required to share the alarm code with beneficiaries?	Residential	In the event that the alarm system is used as a key (i.e. door entry code) to enter the home, the alarm system should be treated as a key and noted accordingly. If having a key to the home and not a code to the alarm system could lead to adverse effects (i.e. alarm triggering intruder response), this is not considered having full access to the home and in turn could be considered a rights violation. Therefore, in the event of any rights restrictions, documentation should be noted in the person centered plan. Further, providers should have policies and procedures that speak to alarm system access to beneficiaries receiving services on residential settings.
Are clients required to have a key to their bedroom doors as well as to their house?	Residential	In the event of any type of rights restriction, such information should be thoroughly documented within the beneficiary's ISP. It may not be appropriate for all beneficiaries to receive a key to the home. Therefore, the provider's policies and procedures should align with HCBS compliance in how such concerns would be addressed for each beneficiary.
Does remediation require a plan of action?	Review	A plan of action should be completed for sites in remediation. The Plan of Action should be noted on the review page of the provider self-assessment as well.
If there is more than 1 Care Coordinator visiting the site, can the site have more than one monitoring logged on the validation reporting tool in the same review period?	Review	Yes. We understand there will be instances where more than one care coordinator monitors a site in the same period. The LME-MCO is responsible for reviewing all Care Coordinator monitoring tools submitted for a site for at least one month in order to validate the site. Each LME-MCO will determine what system works best for them when delegating site validations to care coordination staff.
Does the care coordinator have the authority to request to view provider's policies and procedures?	Review	The review of policies and procedures is a part of the LME-MCOs internal HCBS processes. The determination of who is responsible for such requests will be determined by the LME-MCO.
Will desk reviews be required for in lieu services?	Review	Desk reviews will not be required for in lieu services as this service is not captured in the HCBS Transition group. The LME-MCO should request the sites be deleted by providing a master index request to DHHS.
How should plan of action information be shared amongst LME-MCOs?	Review	LME-MCOs can develop internal processes to share such information with other LME-MCOs. Point of contact information will be shared with all LME-MCOs.

How will the LME-MCO determine when to conduct a desk review?	Review	The LME-MCO will be responsible for creating internal processes that will determine when to complete a desk review. It is noted that Supported Employment-Corporate sites will require a desk review unless an beneficiary is working at the corporate site.
How does the LME-MCO obtain verification of beneficiary's pay rates?	Review	Beneficiaries receiving supported employment on the waiver (Innovations and (b)(3)) should be in competitive, integrated employment. LME-MCO staff may ask beneficiaries or their guardians if they are making at or above minimum wage. Additional measures may be taken if needed.
How will residential support or day support providers increase its staffing patterns to support each beneficiary's personal preference?	Review	The purpose of HCBS compliance is to ensure that beneficiaries are afforded the same rights to access their homes and communities as others living in their same community. Therefore, it is not the expectation that agencies increase staffing patterns to meet this unless there are concerns. Agency policies and procedures should align with HCBS compliance and any rights restrictions should be noted within the beneficiary's person centered plan. Agencies should be mindful of staffing patterns to address preferences. LME-MCOs/CAP-DA can provide technical assistance regarding any concerns that may prevent an agency from meeting HCBS compliance as a result of this concern.
In a home of 3 beneficiaries where 2 beneficiaries want to attend church and 1 beneficiary doesn't, how will the provider accommodate each beneficiary?	Review	The provider should have polices and procedures that speak to decision making processes when the majority of beneficiaries would like to attend one function and the minority do not. Such processes should minimally speak to communication and shared decision making processes.
When completing the provider monitoring tool, how should it be documented when the beneficiary's wishes are in conflict with the guardian's wishes?	Review	Conflict should be logged in the comment's section of the Care Coordinator Monitoring tool. The LME-MCO/CAP-DA are able to provide technical assistance to the beneficiary and/or family regarding beneficiary rights as well. Any restrictions of rights, regardless of if an beneficiary has a guardian, should be documented within the person centered plan and reviewed by appropriate parties. DHHS is available for technical assistance.
Does a day support provider with 100 beneficiaries require 100 care coordination tools to validate?	Review	A site may be validated once care coordinators obtain one full month of data. This number could vary due to the structure of care coordination visits that particular month data is being captured.
How should the LME-MCO validate (b)(3) supported employment?	Review	The LME-MCO is responsible for creating internal processes that will identify the staff and method of review for (b)(3) services.
How many sites do care coordinators have to validate?	Review	CMS requires a 100% validity check by care coordinators, licensing staff or others trained with the requirements of the settings rule. The LME-MCO is responsible for creating internal processes that will support 100% site validation and determining which validation method(s) will be used.
How will Care Coordinators address licensed facilities that contradict HCBS guidelines? (Ex. 122C- 62 (b) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies.	Review	The rule currently is written to reference a minimal time a beneficiary could have visitors.
When is it necessary to complete desk review if care coordinators are completing the HCBS on site review?	Review	The LME-MCO will be responsible for creating internal processes that will determine when to complete a desk review. It is noted that Supported Employment-Corporate sites will require a desk review unless a beneficiary is working at the corporate site.
How can choice be provided for multiple beneficiaries with different preferences with only one staff member?	Review	The provider should have polices and procedures that speak to decision making processes when the majority of beneficiaries would like to attend one function and the minority do not. Such processes should minimally speak to communication and shared decision making processes.
What happens when a LME-MCO fails to update or complete an assessment that effects beneficiaries in other LME-MCOs?	Review	Communication is expected across LME-MCOs to update and complete assessments pending fully integrated/fully compliant status. DHHS is available to provide technical support. The HCBS Standard Operation Procedures Manual outlines this process further.
When a beneficiary's Medicaid transitions to another LME-MCO, would the receiving LME-MCO have to validate the site?	Review	The site will not be revalidated but goes into ongoing monitoring if it has been validated. If the site has NOT been validated, it will require validation by the receiving LME-MCO. It is important for both LME-MCOs to communicate if there is any remediation needed.
Are provider's responsible for beneficiary's overnight guest that may pose safety risks to other beneficiaries in the home?	Review	Providers are responsible for maintaining a healthy and safe environment for all residents. The provider and beneficiary should address any challenges with guest that may pose health and safety risks during Person Centered Planning. Provider policies and procedures should also speak to how concerns are addressed within a residential setting regarding visitors and guests.
Who provides technical assistance during remediation?	Review	The LME-MCO/CAP-DA should be available to provide technical assistance to providers during remediation. DHHS is available to provide technical assistance to the LME-MCOs/CAP-DA during remediation.

Does the LME-MCO make the final determination of HCBS compliance when a provider's policies or procedures are questionable?	Review	The LME-MCO is responsible for validating HCBS compliance or determining if site remediation is required.
How many attempts should an LME-MCO make to provide technical assistance to a provider?	Review	The LME-MCO is responsible for creating internal processes for providing technical assistance to providers. DHHS is available to provide technical assistance to the LME-MCO.
What is the standard timeframe for providers to meet requirements issued during a plan of correction?	Review	The LME-MCO is responsible for creating internal processes regarding remediation timeframes for providers. However, all sites are expected to be validated by March 31, 2020.
What is DHHS's role when a provider and LME-MCO are in disagreement regarding the provider meeting HCBS compliance?	Review	The LME-MCO is responsible for creating internal processes for providing technical assistance to providers. DHHS is available to provide technical assistance to the LME-MCO. In the event a concern is shared with DHHS regarding the process, DHHS will work with the LME-MCO to provide technical assistance regarding the concern. LME-MCOs/CAP-DA are able to bring concerns regarding any site to DHHS at any time.
How does the right to choose daily activities fit into the requirement of beneficiaries being out of the home 4 hours per day?	Review	The person centered planning process should be used to address and document any barriers associated with accessing the community or preferences to remain home during the day.
Is revalidation required when a beneficiary's Medicaid transfer?	Review	The site will not be revalidated but goes into ongoing monitoring if it has been validated. If the site has NOT been validated, it will require validation by the receiving LME-MCO. It is important for both LME-MCOs to communicate if there is any remediation needed.
Is the receiving LME-MCO responsible for determining HCBS compliance for assessments transferred from another LME-MCO in emerging status?	Review	The site will not be revalidated but goes into ongoing monitoring if it has been validated. If the site has NOT been validated, it will require validation by the receiving LME-MCO. It is important for both LME-MCOs to communicate if there is any remediation needed.
How does a care coordinator identify another LME-MCO beneficiary's identity when a HCBS violation incident is observed?	Review	LME-MCO staff should follow internal LME-MCO grievance processes regarding beneficiaries that are not under their purview. DHHS is available to provide technical assistance.
How are beneficiary's complaints captured?	Review	LME-MCO have complaint lines and grievance processes established to address complaints.
What happens if an HCBS concern is noted after a site has been validated?	Review	The LME-MCO or CAP-DA staff would provide technical assistance to a provider to support them to coming back into full integration/compliance. All providers remain in the ongoing monitoring phase indefinitely once a site is validated.
What is the next step for reviewers after validation is completed?	Review	The site will go into ongoing monitoring if it has been validated.
What are the three ways to validate an assessment?	Review	Assessments can be validated via Care coordination (onsite), desk review and intense onsite review. My Individual Experience Surveys can be used with either of these methods, but cannot serve as a sole method of validation.
HCBS Validation is site specific. Providers providing multiple HCBS services at multiple sites supporting multiple beneficiaries are monitored by multiple Care Coordinators. Can one visit for one beneficiary be used	Review	No. Each site requires separate site validation. There must be a full month of data to support site validation for each service.
Are Care Coordinators responsible for completing the HCBS Monitoring Tab for Supported Employment (SE) sites during on-going monitoring?	Review	Yes, the Care Coordinator is responsible for completing the HCBS Monitoring Tab for SE sites during on-going monitoring.
Regarding the Care Coordination HCBS criteria monitoring checklist: Evidence/Observations of personal preference assessments to identify the kinds of work and activities individual wants to participate in. Is it required that the preference assessment(s) be onsite at the actual site of service provision?	Review	Depending on an agency's policies and procedures, assessment protocol may look different for each and is determined on a case-by-case basis depending on the service (ie. Adult Day Health, Residential, Supported Employment, etc.). Therefore, though preference assessment should be with the individual, assessment protocol may not necessarily be onsite. Furthermore, full integration is noted by evidence/observation that the setting's established practices ensure individuals plan weekly meals, activities, and timing of these, that individual choices are in line with available resources, and that each individual's plan is unique to that individual. For additional guidance, please reference the HCBS Self-Assessment Review Guide. It's further noted that the person-centered process involves a person's likes and dislikes and requires obtaining information on an individual's needs, wants, and preferences.
If we have a site that is out of our catchment that is not compliant within the HCBS database, how do we tell which MCO reviewed it to be able to follow up?	Review	If you are aware of the site location, the location of the site dictates which LME-MCO is responsible for reviewing and validating the site unless that LME-MCO is not contracted with that site. At this point, it would be the contracted LME-MCO's responsibility to review and validate the site. It is recommended to use the reviewing entity's HCBS email address previously provided to communicate across LME-MCOs regarding such concerns. Inquiries may also be made to HCBSTransPlan@dhhs.nc.gov.

The question on the Care Coordination Monitoring Checklist is written, "Observation that the individual has a key to the home and his/her room", which indicates the need for a key to both. Will this be updated on the monitoring checklist if it is not required that the individual have a key to both?	Review	In the event of any type of rights restriction, such information should be thoroughly documented within the beneficiary's ISP. It may not be appropriate for all beneficiaries to receive a key to the home. Therefore, the provider's policies and procedures should align with HCBS compliance in how such concerns would be addressed for each beneficiary. This question on the Care Coordination Monitoring Checklist will remain the same as the item can be marked met or not met dependent on the beneficiaries preferences as documented in the beneficiary's person-centered plan or Individual Support Plan. For example, if the Care Coordinator observes the beneficiary has a key to their home but not their bedroom and this is documented in the person-centered plan, then this is sufficient support for the item to be met. However, it is necessary that Care Coordination Monitoring is being completed to ensure observation that bedroom doors have the ability to be locked, that door knobs/locks are not inverted allowing for the beneficiary to be locked inside the bedroom, and that issues are identified and reviewed for possible remediation efforts.
If a Care Coordinator observes that a site is in full compliance for their member but possibly out of compliance for another LME-MCO's member at the site, would the site be out of compliance?	Review	There must be a full month of data to support site validation for each site. Therefore, if multiple beneficiaries are at the site receiving Care Coordination visits from multiple Care Coordinators, then muliple Care Coordination Monitoring Checklists would be used for validation and any issues would need to be reviewed for possible remediation efforts. It is recommended to use the HCBS email addresses previously provided to communicate across LME-MCOs regarding such concerns. Any concerns must be remediated prior to a site being validated.
There is some confusion on how supported employment will link with the provider self-assessment, My Individual Experience Survey and validation. Is the validation process only for corporate sites? Will Supported Employment corporate sites be validated by desk review (as Care Coordinators generally do not monitor services at Supported Employment corporate sites)?	Supported Employment	Supported employment validation will be completed at the employment site, since this is typically where the Care Coordination Monitoring is completed. Supported employment corporate sites will require a desk review or intense onsite review unless there is an beneficiary employed at the provider site.
What if the work schedule for the beneficiary appears to prejudice the beneficiary in comparison to workers without an I/DD?	Supported Employment	LME-MCOs should provide technical assistance to the provider site to support in reaching HCBS compliance. Larger issues should be addressed on a scale outside of HCBS requirements. Supported Employment includes educating the employer.
Is a new provider self assessment required when a beneficiary obtains a new job?	Supported Employment	Providers are not required to submit a provider self assessment for any new sites, except if it is a new provider or acquired provider that needs to submit a supported employment-corporate site assessment. Supported employment should only be provided in competitive, integrated settings. Therefore, new supported employment sites should meet such requirements.
Do LME-MCOs have the authority to make recommendations to supported employment providers?	Supported Employment	LME-MCOs have the authority to review the supported employment provider's policies and procedures. However, the LME-MCO does not have the authority to review the actual job site policies and procedures unless the beneficiary is employed at the corporate site.
Providers and LME-MCOs were previously advised that supported employment sites were required to submit provider self-assessments for the corporate sites and 10 or 10% (whichever greater). Are they now required to submit assessments for all existing sites?	Supported Employment	Providers are not required to submit a provider self assessment for any new sites, except if it is a new provider or acquired provider that needs to submit a supported employment-corporate site assessment. Supported employment should only be provided in competitive, integrated settings. Therefore, new supported employment sites should meet such requirements.
For Supported Employment Corporate Site. When we are reviewing the Provider, are we only looking at the boxes that indicate "Corporate Site Only" for compliance? Or are we addressing all of the checked boxes for Supported Employment in that column?	Supported Employment	When completing a desk review for a Supported Employment Corporate Site, all items for Supported Employment must be addressed in addition to those identified as "Corporate Site Only".
Can supported employment sites be validated by the Care Coordinator?	Supported Employment	Care Coordinators are able to complete care coordination on site reviews at the beneficiary's supported employment site.
Is there a way for the State to push out the end date on this task beyond March 1, 2020 to take of some of the intensity of reviewing all the providers?	Timelines	No. March 31, 2020 is the date outlined in the DHHS STP to achieve 100% validation. DHHS will also monitor quarterly progress to provide technical assistance.
What is the [validation] timeframe for remediation of the Plan of Action, if one is issued? Will the Plan of Action be entered into the existing HCBS assessment and tracked?	Timelines	During the validation process, if it is determined that remediation is needed, LME-MCO/CAP-DA will be expected to work with the provider to determine the appropriate plan of action to ensure compliance and validation by March 31, 2020. The plan of action timelines will be tracked on the quarterly validation tool as well as pertinent information will be included in Provider Self-Assessment review page on the HCBS database. It is important that providers and LME-MCO/CAP-DA staff do not delete historical information as new information is being entered.

Would the validation process be applicable for any provider self-assessments submitted after Jan 2019 and after the end date of March 2020.	Timelines	No. All new providers submitting assessments should be in compliance prior to starting services; therefore they would not be part of the transition plan and validation process. However, these sites should continued to be monitored for HCBS compliance. Only the sites noted in the Validation Quarterly Report are considered a part of the transition.
Is the LME-MCOs validation process a 6-month timeframe?	Timelines	Validation is from April 1, 2019 to March 31, 2020.
What is the timeframe for DHHS unlocking provider self-assessments [on the Validation Quarterly Reporting Tool]?	Timelines	DHHS will unlock provider self-assessments on the Validation Quarterly Reporting Tool within 14 business days and return the Validation Reporting Tool to reflect such updates.
What is the expectation of providers that are in noncompliance by March 31, 2020?	Timelines	The expectation for providers that remain out of compliance to the HCBS final rule after March 31, 2020 is to have a plan to transition their beneficiaries to a HCBS compliant site.
How often will DHHS capture data?	Timelines	The Validation Quarterly Reporting Tool is due 8/5/19, 11/5/19, 2/5/20 and 5/5/20.
Can a site be validated prior to May 1, 2019?	Timelines	No. Sites may not be validated prior to May 1, 2019.
What date is used for “Date Site Validated” on the validation reporting tool? Is it the date the care coordinator did the monitoring?	Tool	The date the information is reviewed by designated LME-MCO staff and determined site to be validated.
Is the review tool only used for desk review or intense onsite reviews?	Tool	Yes! The DHHS HCBS Review Tool is used for the desk review or intense onsite reviews. Care Coordinators should continue using the existing Care Coordinator Review Tool-HCBS Monitoring Check Sheet tab.
What information will the care coordinator receive on the Validation Quarterly Reporting tool?	Tool	The Care Coordinator is not required to obtain any information on the Validation Quarterly Reporting Tool. Information they submit to the LME-MCO will be captured on the validation quarterly reporting tool.
When will the desk review tool become available for use?	Tool	The desk review tool will be available no later than April 1, 2019.
What types of documents are utilized for a desk review process?	Tool	The documents that can be utilized for desk reviews are the Provider Self-Assessment, Provider Policies and Procedures and Individual Support Plans.
Do LME-MCOs have to submit a master index request for duplicates found on Validation Quarterly Reporting Tool?	Tool	A Master Index Request is not required for duplicates found on the Validation Quarterly Reporting Tool. This action can be completed by selecting the “Duplicate-remove from system option on the tool” in lieu of a Master Index Request.
Are LME-MCOs required to maintain records of all validation methods used to validate a site?	Tool	Yes. LME-MCOs are required to maintain records of all methods used to validate a site. DHHS may request such documentation during their look behind.
What is the documentation process for a provider validated through use of the Care Coordination Monitoring tool and My Individual Experience Survey?	Tool	The Validation Quarterly Reporting tool should be used to document the methods used for validation.
When should the HCBS Review tool be used?	Tool	The HCBS Review tool should be used during a desk review and intensive on-site review.
Will the state provide a spreadsheet with site specific provider self-assessments and completed My Individual Experience Surveys linked to those same sites? While it’s likely not every site with a self-assessment will have a corresponding My Individual Experience Survey, having MCO’s independently match data that is already in the state’s databases appears as though it could increase the potential for error.	Tool	DHHS will provide each LME-MCO and CAP-DA with a spreadsheet of information that includes the provider sites required for validation. Participants should continue to be provided survey codes to support in streamlining the information. During the validation process, DHHS will support by reviewing My Individual Experience Survey database information and providing My Individual Experience Survey results that have met the threshold to the applicable LME-MCO and CAP-DA or that have answered one or more threshold questions unfavorably. DHHS will support with identifying the coordinated site with these assessments.
Are we correct in understanding that this [Validation Quarterly Reporting tool] is the form that is used to request corrections to the Master Index? If not, which form is used?	Tool	Anything that is not listed under "Actions" on the Validation Quarterly Reporting tool should be submitted through a Master Index Request. Master Index requests are sent to HCBStransplan@dhhs.nc.gov.
What is a Master Index Request?	Tool	The Master Index Request is an Excel document used with LME-MCOs prior to the Validation Quarterly Reporting tool. It is an ongoing log of all (past and present) changes and includes all demographic information about the site, site name, assessment number, and action needed (ie. duplicate site deletion, LME-MCO transfer, etc.). Master Index Requests are required for all sites entered into the HCBS Database 1/1/2019 or later or for anything that is not listed under "Actions" on the Validation Quarterly Reporting tool.
We have been cross referencing [our] data with the data provided in the Validation Quarterly Report. The data comparison is off by a significant number of sites as well as incorrect addresses. Has any other LME/MCO had this issue? What is the possible issue with the extreme variance in numbers?	Tool	If it's been identified that a current provider failed to submit a provider self-assessment, an HCBS Provider Self-Assessment must be completed and HCBS Emergent Procedures outlined in the HCBS SOP Manual & Guidance must be followed.

Could assessments with slight variations in site name (ie. Dr. vs. Drive, John Smith Home vs. John Smith AFL) be duplicates if all other demographic information matches?	Tool	Yes, if all other demographic information matches, an assessment with slight variation in site name can be marked as duplicate on the Validation Quarterly Reporting tool. Note, this does not apply to variations in site name due to indication of site 'dba' or change in providers, site location, or other demographic information.