# HCBS Standard Operating Procedures

North Carolina supports serving individuals with disabilities in the most integrated settings possible, based on what is clinically appropriate as defined by the individual's person-centered planning process.

We believe that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards.

Through engaging beneficiary and provider stakeholders, we will create a plan that supports individuals through a person-centered process, builds upon our already existing system and supports providers to ensure compliance with rules. This webpage details North Carolina's vision of Home and Community Based Services.

The Centers for Medicare & Medicaid Services (CMS) published a final rule for Medicaid Home and Community Based Services effective March 17, 2014. The rule allows beneficiaries access to the benefits of community living and receiving services in the most integrated setting and provides alternatives to institutions. Additional information can be found at Medicaid.gov.

## Overall Purpose of HCBS Final Rule

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.

*Please refer to www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule for additional information.*

## Timelines

North Carolina's site validation process starts April 1, 2019 and ends March 31, 2020. Within all procedures and processes noted within this document, **ALL** sites within the transition period **MUST** be Full Integration/Fully Compliant AND validated by March 31, 2020. All new sites outside of the transition period must be Full Integration/Fully Compliant PRIOR to providing services.

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## <u>HCBS Provider Self-Assessment Reviewing Entity</u>

*If a site/self-assessment is shared among two or more LME-MCOs, 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 their (LME-MCO-1's) catchment area and

- **<u>IS</u>** 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.
- **<u>IS NOT</u>** contracted with LME-MCO-1, the LME-MCO that <u>is</u> contracted with that provider is expected to review the site's provider self-assessment, validation (if applicable), and ongoing monitoring for the site.

If multiple provider self-assessments are shared between 2 or more LME-MCOs:

- The catchment area LME-MCO is responsible for the validation (if applicable)
- The LME-MCOs who have assessments submitted for shared sites outside of their catchment area should submit a Master Index request to delete the duplicate sites.

Shared sites identified during the validation process (April 1, 2019-March 31, 2020) should follow the guidance identified for submitting Master Index requests during this period.

## Provider Address Change

*DHHS encourages the LME-MCO to ensure providers offer advanced notice to the LME-MCO of plans to move to a new location. This practice will provide the LME-MCO the opportunity to confirm/validate HCBS compliance at the new site location. All new sites must be HCBS compliant prior to providing any services at the site.*

Once the LME-MCO has been notified of a provider's intent to change their physical address, the LME-MCO should request the provider to submit a new assessment for the future address.

The reviewing entity will complete the following steps:

1. Identify the original/current provider self-assessment(s) and at the bottom of the self-assessment, select "Not Accepted". Supply a brief description within the comments field as to the reason for being not accepted, notating the new assessment number and utilizing the applicable language below. For archival purposes, this assessment will not be deleted from the system.
2. Identify the new provider self-assessment(s) for the future address and supply a brief description within the comments field utilizing the applicable language below.

**Language for Comments Field of Original/Current Assessment:**

*This assessment is not accepted as assessment #XXXXXXX is a re-submission due to a provider address change.*

**Language for Comments Field of New Assessment:**

*This assessment is a re-submit of assessment # XXXXXXX due to a provider address change.*

Since the newly submitted provider self-assessment falls outside of the transition period, the LME-MCO will need to provide specific technical assistance and deadlines to providers to reach full compliance within a reasonable amount of time given an item that is not compliant.

# Provider Acquisition

*DHHS encourages the LME-MCO to ensure providers offer advanced notice to the LME-MCO of plans to acquire an existing provider.*

*A provider acquisition is defined as one provider agency completely purchasing another provider agency or site location, requiring the acquired agency or site to operate under new policies and procedures, a new provider or site name, and/or new demographic information.*

Once the LME-MCO has been notified of a provider acquisition, the LME-MCO will request the provider to submit a new assessment for acquired site location(s). This is required due to the potential of new demographic information, policies, and procedures, which could have an impact on HCBS waiver services.

The reviewing entity will complete the following steps:

1. Identify the original to-be acquired provider self-assessment(s) and at the bottom of the self-assessment, select “Not Accepted”. Supply a brief description within the comments field as to the reason for being not accepted, notating the new assessment number and utilizing the applicable language below. For archival purposes, this assessment will not be deleted from the system.
2. Identify the new provider self-assessment(s) and supply a brief description within the comments field utilizing the applicable language below.

**Language for Comments Field of Original/Current Assessment:**

*This assessment is not accepted as assessment #XXXXXXX is a re-submission due to a provider acquisition.*

**Language for Comments Field of New Assessment:**

*This assessment is a re-submit of assessment # XXXXXXX due to a provider acquisition.*

Since the newly submitted provider self-assessment(s) falls outside of the transition period the LME-MCO will need to ensure the site is fully compliant within **10 business days of acquisition**.

1. Review newly submitted assessment and determine if HCBS criteria has been met.
2. If assessment is considered fully integrated, no additional review is required.
3. If the assessment is considered “emerging,” the LME-MCO will need to provide technical assistance to ensure HCBS compliancy/full integration is achieved within the 10-business day timeframe.

## Provider Agency or Site Doing Business As ('dba')

*DHHS encourages the LME-MCO to ensure providers offer advanced notice to the LME-MCO of plans to acquire an existing provider and operate as 'dba'.*

If the LME-MCO has been notified of a site operating as 'dba' (doing business as), the LME-MCO should obtain enough information to identify one of the following scenarios and actions:

If the provider agency or site identified as 'dba' is a true ***provider acquisition***, as defined in the previous section, then a new assessment for the site will be required. All actions should be completed as outlined within the **Provider Acquisition** section.

If the provider agency or site identified as 'dba' with a variation in provider or site name between the provider self-assessment and the LME-MCO's records **AND**

A. The NPI # and Tax ID # **remain the same**:
   1. A new assessment for the site is not required.
   2. The LME-MCO should submit a Master Index request to update the provider or site name utilizing the language below.
   3. *Please note, it is the LME-MCO's responsibility to identify any potential duplicate assessments within the HCBS database, that may be a result of this scenario, and complete any necessary actions.*

**Language for Master Index request:**

> *Provider "X" associated with Assessment #XXXXXXX has been identified as "doing business as" with no change to NPI # or Tax ID #. Please update provider name/site name to reflect, "X".*

B. Either the NPI # **OR** the Tax ID # **are different**:
   1. A new provider self-assessment for the site is required.
   2. The LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days.
   3. The LME-MCO will supply a brief description within the comments field of the new assessment utilizing the applicable language below.
   4. The LME-MCO will identify the original provider self-assessment and at the bottom of the self-assessment, select "Not Accepted". Supply a brief description within the comments field as to the reason for being not accepted, notating the new assessment number and utilizing the applicable language below. For archival purposes, this assessment will not be deleted from the system.

**Language for Comments Field of Original/Current Assessment:**

> *This assessment is not accepted as assessment #XXXXXXX is a re-submission due to identification of provider/site "doing business as".*

**Language for Comments Field of New Assessment:**

> *This assessment is a re-submit of assessment # XXXXXXX due to identification of provider/site "doing business as".*

## HCBS Emergent Procedures

*Emergent refers to a situation in which placement or provision of services for a beneficiary is required within a limited timeframe.*

Where emergent accommodation is utilized for an HCBS participant, the following procedures apply:

- Emergent accommodation may be utilized as a temporary or permanent measure only where all alternatives have been exhausted, such as respite and family network. Emergency placement is determined by LME-MCO, not the provider.

*In-Network Provider*: If emergent placement or provision of services occurs within the authorizing LME-MCO network AND the provider site (not a part of the transition period) has not been considered HCBS compliant:

- LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days of placement or provision of services.
- If HCBS compliance cannot be reached in the 5-business day period, the LME-MCO will need to decide if HCBS compliance can be made with increased technical assistance and plan of action within 30 days from placement or provision of services or look for a more permanent HCBS compliant home/setting.

*In-Network Provider*: If emergent placement or provision of services occurs within the authorizing LME-MCO network AND the provider site has not completed an HCBS Provider Self-Assessment:

- Provider has 72 clock hours to complete the Provider Self-Assessment. LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days of completed date of newly submitted assessment.
- If HCBS compliance cannot be reached in the 5-business day period. If HCBS compliance cannot be reached in the 5-business day period, the LME-MCO will need to decide if HCBS compliance can be made with increased technical assistance and plan of action within 30 days from placement or provision of services or look for a more permanent HCBS compliant home/setting.

*Out-of-Network Provider*: If emergent placement or provision of services occurs outside of the authorizing LME-MCO provider network AND the provider site has not been considered HCBS compliant:

- <u>Provider Within Transition Period</u>: The new LME-MCO will review the HCBS Provider Self-Assessment and remediate concerns with the current LME-MCO. If the provider self-assessment was listed on the LME-MCOs Validation Quarterly Reporting Tool, the site is considered part of the transition period. Any sites not listed would fall under new provider status. Sites in the transition period do not have to be fully compliant for emergent placement.

*Out-of-Network Provider*: If emergent placement or provision of services occurs outside the authorizing LME-MCO network AND the provider has NOT completed a HCBS Provider Self-Assessment.

- Provider has 72 clock hours to complete the Provider Self-Assessment. LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days of completed date of newly submitted assessment.
- If HCBS compliance cannot be reached in the 5-business day period, the LME-MCO will need to decide if HCBS compliance can be made with increased technical assistance and plan of action within 30 days from placement or provision of services or look for a more permanent HCBS compliant home.

## LME-MCO Site Assessment Transfers

In the event an LME-MCO receives an assessment that belongs to another LME-MCO and they have **NOT REVIEWED** the assessment:

1. Submit a Master Index request to move assessment to the responsible LME-MCO.

In the event an LME-MCO receives an assessment that belongs to another LME-MCO and the assessment has been **REVIEWED** ONLY. *Reviewed is defined as the reviewing entity staff has assigned an integration/compliance level to the responses/information noted by the provider site in the provider self-assessment.

1. The LME-MCO that initially reviewed the assessment will identify the responsible LME-MCO to discuss the transfer of the assessment.
2. The LME-MCO that initially reviewed the assessment will submit a Master Index request to move the assessment to the responsible LME-MCO. Information regarding the discussion with the receiving LME-MCO must be included in the request (i.e. forwarded communication between LME-MCOs).
3. DHHS will initiate communication with the receiving LME-MCO to confirm they are in agreement with the transfer of the assessment.

In the event an LME-MCO has **REVIEWED and ACCEPTED** an assessment that belongs to another LME-MCO and the receiving LME-MCO is in **AGREEMENT** with provider responses:

1. The LME-MCO that initially reviewed the assessment will identify the responsible LME-MCO to discuss transfer.
2. The LME-MCO that initially reviewed the assessment will submit a Master Index request to move the assessment to the responsible LME-MCO ensuring information regarding the discussion with the receiving LME-MCO is included in the request.
3. DHHS will initiate communication with the receiving LME-MCO to confirm they are in agreement with the transfer of the assessment.
4. If the newly reviewing LME-MCO agrees with provider responses, the process is complete and that LME-MCO will be responsible for any Plans of Action and further review.

In the event an LME-MCO has **REVIEWED** and **ACCEPTED** an assessment that belongs to another LME-MCO and the receiving/newly reviewing LME-MCO is **NOT IN AGREEMENT** with provider responses:

1. The receiving/newly reviewing LME-MCO will contact the LME-MCO that completed the initial review to discuss the responses and develop plan to reach a resolution.
2. At the conclusion of the discussion, the assigned LME-MCOs will only follow up specific to Plans of Actions, and no immediate action will be required unless there is still non-agreement with the findings.
    a. **HCBS Database Update:** If the reviewing LME-MCO does not agree with the findings, the assigned LME-MCO will "Pending/Questions" within the provider self-assessment to address discrepancies or the assigned LME-MCO will update the provider self-assessment with any remediation information to address concerns.

3. If resolution is not possible DHHS should be notified to provide technical assistance and remediate.
4. The LME-MCO that completed the initial review will submit a Master Index request to move the assessment to the responsible LME-MCO. Information regarding the discussion with the receiving LME-MCO and follow-up completed must be included in the request.
5. DHHS will initiate communication with the receiving LME-MCO to confirm they are in agreement with the transfer of the assessment.
6. The process, from that point, will continue as previously established.

*Please note, as HCBS requirements are only one component of a provider's overall expectations to provide HCBS waiver services, the HCBS provider self-assessment does not dictate when transfers are effective, and the date of transfer should fall under guidelines issues by NC Medicaid.*

- *As it relates to HCBS provider self-assessments for sites within the transition period, the status of the provider self-assessment should not cause delay in the provision of services.*

*As it relates to HCBS provider self-assessments for sites outside of the transition period, entered on or after January 1, 2019, providers are unable to provide HCBS waiver services until the assessment is deemed full integration/fully compliant; however, the transfer date could precede this as it may be possible for this date to differ from the service authorization date for the HCBS service in question. For example, a provider may have multiple services and sites, and a new AFL site should not deter the provision of other services that may not require a provider self-assessment or sites that may be within the transition period.*

## <u>Provider Contract Termination</u>

In the event an LME-MCO would like to terminate an existing provider contract, and another LME-MCO would like to continue working with or enroll the provider site, the process is as follows:

1. Contact the provider and notify intent to terminate contract and follow their contract process for provider termination.
2. Receive, from the provider, the LME-MCO(s) they are currently working with or are interested in enrolling within their provider network, if applicable.
    a. If this information is known, the LME-MCO would follow the steps outlined in the section **LME-MCO Site Assessment Transfers** <u>to ensure transfer of assessment.</u>
        i. Both LME-MCOs will submit a Master Index to HCBSTransPlan@dhhs.nc.gov with a request to reassign the assessment to the correct LME-MCO utilizing the language below.
    b. If this information is unknown to the LME-MCO, the LME-MCO would mark the assessment as "Not Accepted" and add language within the comment box as to the reason for not accepted.
    c. In the event that an LME-MCO has been made aware that a new provider or existing provider in their catchment area has an assessment in the system, this information may be requested from the HCBSTransPlan@dhhs.nc.gov email.
    d. Discussions between both LME-MCOs will need to take place and updates to the HCBS database made accordingly.

**Language for Master Index request (if applicable):**

**Requesting LME-MCO**: *Provider "X" associated with Assessment "X" has been terminated from "Requesting LME-MCO's" network and requesting transfer to "Receiving LME-MCO" for network enrollment and ongoing HCBS monitoring.*

**Receiving LME-MCO:** *Provider "X" associated with Assessment "X" has been accepted for network enrollment and ongoing HCBS monitoring.*

## Sites No Longer Providing HCBS Waiver Services

In the event that a site:

- Falls within the transition period (assessment prior to 12/31/2018),
- Is contracted with an LME-MCO/CAP-DA, but
- Not currently providing HCBS waiver services and
- There is no intent to provide HCBS waiver services before the validation period ends, the process is as follows:
    1. The reviewing entity should mark the provider self-assessment as "Not Accepted" and
    2. Supply a brief description, utilizing the applicable language below, within the comments field as to the reason for being not accepted.

**Language for Comments Field of Assessment:**

*After confirmation with the provider/site, this assessment is being marked "Not Accepted" as provider/site is not currently providing HCBS waiver services and does not intend to provide HCBS waiver services in the future.*

In the event the provider/site wishes to begin to provide HCBS waiver services again in the future, the following steps should be taken:

- **Within the validation period**, the reviewing entity should:
    1. Within the provider self-assessment, pend questions to the provider requesting they provide an updated response to each applicable question.
    2. Once the reviewing entity accepts the provider/site's plan of action toward HCBS compliance, mark the assessment "Accepted" within the HCBS database.
- **Outside the validation period**, the reviewing entity should:
    1. Request the provider complete a new HCBS self-assessment.
    2. Compliance with HCBS is required prior to starting services.

*Please note, prior to marking the assessment "Not Accepted" for this scenario, it's important the LME-MCO has established policies and procedures for ensuring the status of the site is accurate and tracking the status of the site in the event the provider/site intends to provide services at a later date.*

## Validation Quarterly Reporting

*When selecting an action for a site assessment on the Validation Quarterly Reporting tool, the information below should be considered, and any necessary steps completed.*

**Duplicate- remove from database**

- A true duplicate is an assessment whose demographic information matches another assessment's exactly.
- Consideration should be given to retaining the assessment with pended questions, provider response, additional content, etc.
- Separate HCBS assessments are required if multiple services are provided at the same site. These assessments would not be true duplicates.
- If a site changed provider, site names, etc., the previous assessment is **NOT** a true duplicate and will require the reviewing entity to complete the following steps:
    1. At the bottom of the previous/initial provider self-assessment, select "Not Accepted".
    2. Supply a brief description within the comments field as to the reason for being not accepted. For archival purposes, this assessment will not be deleted from the system.
- If a site assessment indicates the site is in operation as 'dba' (doing business as), the previous assessment is **NOT** a true duplicate and the reviewing entity should treat the assessments as a Provider Acquisition and complete necessary steps.
- If a site assessment is identified as a true duplicate and:
    - **IS** within the transition period/on the validation quarterly report, then "Duplicate- remove from database" action should be selected on the tool.
    - **IS NOT** within the transition period/not on the validation quarterly report, then a Master Index must be submitted to HCBSTransPlan@dhhs.nc.gov.

**Identified as Corporate Site**

- Corporate Sites only apply to Supported Employment
- Validation is still required for sites identified as Corporate Sites
- Supported Employment Corporate Site assessment must include site address

**Wrong catchment area- remove**

1. Identify the LME-MCO to transfer the assessment to on the tool
2. Verify that the receiving entity is aware of the transfer
3. Select 'Verified with receiving LME-MCO' in the Verification column.

**Site is now fully compliant- please unlock**

- Site fully compliant is different than validated
- This is only to be selected if the site assessment was originally formatted with bold font and underlined, and the cells could not be manipulated

**Site not accepted- unwilling or unable to comply**

1. At the bottom of the self-assessment, select "Not Accepted"
2. Supply a brief description within the comments field as to the reason for being not accepted.

**Erroneous Assessment- remove from database**

- This action can be selected for those assessments truly entered in error and should not be in the database.
- An example of this might be an assessment where random characters were entered for each response
- This action does not apply to duplicates, wrong catchment area, or not accepted/unwilling or unable to comply.

**Additional Information and Considerations for Validation**

- If an assessment is marked "Not Accepted", a brief description should be entered within the comments field as to the reason for being not accepted.
- As self-assessments are reviewed, for residential providers, it is important to notate the number of individuals residing in the home.
- Master Index requests, submitted to HCBSTransPlan@dhhs.nc.gov are required for items not noted under "actions" on the Quarterly Validation Reports and/or assessments
- Validation Q&A Document
- Validation Webinar (training on the tool at 31:30)
- HCBSTransPlan@dhhs.nc.gov

**DHHS HCBS Validation Look-Behind**

*The DHHS HCBS Internal Team will complete desk reviews on a sample of validated settings utilizing documentation that the LME-MCOs and CAP-DA used to validate a setting deemed full integration-fully compliant. This documentation could include review of the Care Coordination Monitoring Tool(s), MIE Surveys, provider self-assessments, and any policies or procedures that may have been used or noted. This process will begin starting at the receipt of first quarter validation reports.*

*The sample size selected for review is determined using Raosoft Sample calculator http://www.raosoft.com/samplesize.html. The sample sites as well as a generated list of 'spares' is determined using RAT-STATS and includes all settings (Adult Day Health, Day Supports, Residential, and Supported Employment).*

*In the event that the DHHS HCBS Internal Team confirms a site, identified during the LME-MCO/CAP-DA's validation process as "No longer contracted with LME-MCO/CAP-DA-remove", "Duplicate- remove from database", "Erroneous Assessment- remove from database", or "Site not accepted/unwilling or unable to comply" and is part of the random sample, a substitute site will be selected from the generated list of 'spares'. The quantity of 'spares' generated may be updated throughout the look-behind process as necessary.*

The process is as follows:

1. Through HCBSTransPlan@dhhs.nc.gov, the DHHS HCBS Internal Team will request all documentation used by the LME-MCO/CAP-DA to validate a site deemed full integration-fully compliant.
    a. At any time during the look-behind process, if the LME-MCO identifies a site selected as part of the look-behind sample is no longer contracted or no longer active, the LME-MCO/CAP-DA will complete steps outlined in the **HCBS SOP: Validation Quarterly Reporting** and notify the DHHS HCBS Internal Team via email to HCBSTransPlan@dhhs.nc.gov.
    b. The HCBS Internal Team will request documentation used by the LME-MCO/CAP-DA to validate a site deemed full integration-fully compliant for a substitute site.
    c. The LME-MCO will provide all requested documentation, through the applicable pre-established Secure FTP HCBS site, by transferring it to the folder titled, '**DHHS Validation Look-Behind**' within 14 business days of the request.
2. The LME-MCO/CAP-DA will provide all requested documentation, through the applicable pre-established Secure FTP HCBS site, by transferring it to the folder titled, '**DHHS Validation Look-Behind**' within 14 business days of the request. Documentation should include the following:
    a. Care Coordination Monitoring Tool(s)
    b. HCBS Review Tool (utilized for desk reviews)
    c. MIE Survey ID # (if applicable)
    d. Provider policies and/or procedures (if applicable)

3. The DHHS HCBS Internal Team designee will save all documents submitted to the Secure FTP HCBS site to the applicable quarter "Look-Behind Site Documentation" folder found within the HCBS Transition Plan folder located on the NC DMH/DD/SAS server.
4. The DHHS HCBS Internal Team will conduct desk reviews for all sites that are a part of the selected sample.
    a. Utilizing the DHHS HCBS Review Tool, the DHHS HCBS Internal Team will conduct desk reviews within 30 business days of the identified due date to receive site-specific documentation from all LME-MCOs/CAP-DA.
        i. If additional information is required for review, the DHHS HCBS Internal Team will request this information via email from the LME-MCO/CAP-DA and will have an additional 14 business days to review all documents and provide a summary of findings.
    b. If an onsite review is determined necessary, the DHHS HCBS Internal Team will notify the LME-MCO of noted concerns and request an onsite review be completed.
    c. The LME-MCO will conduct onsite reviews of the setting(s) and submit findings via email to HCBSTransPlan@dhhs.nc.gov within 14 calendar days of the onsite review request.
        i. If state representation from the DHHS HCBS Internal Team is desired for an onsite review, a request can be made via email to HCBSTransPlan@dhhs.nc.gov.
5. The DHHS HCBS Internal Team will provide a summary of concluding findings and any remediation efforts to each LME-MCO within 45 business days of receipt of site-specific documentation. The DHHS HCBS Internal Team will identify any need for remediation or follow-up and be available for ongoing technical assistance throughout the process.

**LME-MCO/CAP-DA Look-Behind Follow-Up Considerations**

- Notate pended questions and/or follow-up completed with the provider within the HCBS Provider Self-Assessment.
- Complete a thorough and strategic review of all follow-up responses and evidence submitted by the provider.
- Submit all findings and any remediation completed via email to HCBSTransPlan@dhhs.nc.gov. This could include, but is not limited to:
    - Correspondence with the provider
    - Updated Care Coordination Monitoring tools
    - Policies reviewed by the LME-MCO/CAP-DA
    - Policies updated by provider
    - Provider forms or specific documentation
- The DHHS HCBS Internal Team will pull updated HCBS Provider Self-Assessments for review of any information added to the self-assessment

## My Individual Experience (MIE) Survey Threshold Reports

*Threshold Reports include all MIE Surveys where 1 or more threshold questions are triggered; answered with a response of 'No'.*

- *These reports include all MIE Surveys where 1 or more threshold questions are triggered as there is a potential that one adverse answer could impact a beneficiary's service.*
- *DHHS is not requesting that internal processes be ended or replaced, but that survey data is reviewed, and applicable/necessary follow-up is identified and completed.*

*Reports will be provided to each LME-MCO/CAP-DA on a quarterly basis for review and any necessary follow-up or remediation and should be returned to DHHS within 45 days of receipt.*

When reviewing entities are reporting findings, the following should be considered:

- **"Actions Taken":** Select the appropriate follow-up completed, by the reviewing entity, necessary to address the result of the threshold question(s) triggered.

- **"Status"**: This section captures the current status of follow-up completed by the reviewing entity.
  a. **Open: Under Initial Review:** These are surveys which are being reviewed but have not yet had follow up action.
  b. **Open: Action(s) Have Been Taken in Follow-Up Phase:** These are surveys which are in the process of having follow-up completed as a result of initial review.
  c. **Closed: Identified Issue(s) Resolved:** These are surveys which required action to address identified issues and action has been completed.
  d. **Closed: No issues identified:** These are surveys which were reviewed, follow-up was completed, and no issues were identified; evidence did not support the threshold trigger.

- **"Reviewing Entity Findings":** Select the appropriate option based on findings resulting from review and follow-up action.
  a. **Substantiated**: This should be selected if evidence supported threshold trigger and required follow-up action. This finding should be accompanied by a comment in the 'Reviewing Entity Comments' field.
  b. **Unsubstantiated**: This should be selected if evidence did not support threshold trigger. This should be accompanied by a comment in the 'Reviewing Entity Comments' field.
  c. **Unable to Process:** This should be selected if the survey was unable to be processed due to random characters being entered for responses or insufficient information provided to identify provider. **If this finding is selected, a brief comment must be provided indicating the reason it was unable to be processed.**

- "**Issues/Corrections Needed":** This section captures the need for follow-up by DHHS as identified during review.
  a. **Transfer to:** This action can be selected for those surveys identified as belonging to another reviewing entity due to error in data entry.

i. In the event a request is made to transfer the MIE Survey to another LME-MCO and it is confirmed and approved, the transfer will be completed in the database.

**Master Index Duplicate, Shared and Multiple Site Guidance**

| Service Type | Technical Assistance |
|---|---|
| Day Supports & Adult Day Health | The LME-MCO should submit a Master Index request to have duplicate Adult Day Health site removed if site assessment is not listed on Quarterly Validation Report |
| Innovations & (b)(3) Supported Employment | The LME-MCO should submit a Master Index request to have duplicate (b)(3) site removed if site assessment is not listed on the Quarterly Validation Report. |
| Innovations Residential Supports & (b)(3) DI Residential Supports | Request the LME-MCO submit request to have duplicate (b)(3) DI site removed. |
| Any other service bundle | LME-MCO will need to review the following for accuracy:<br>• Did the provider select the appropriate service? Was this attributed to a drop-down error?<br>• Is this attributed to the site being a corporate site for supported employment or are individuals working at the site?<br>    o In the event that it is a corporate site, this should be noted on a Master Index request.<br>• The only site that should have a corporate site representation is supported employment. All other sites should speak to where services are being provided.<br>    o Special attention should be paid towards multiple site names at the same address. |
| Duplicate Assessments: Due to entry errors (i.e. Drive vs. Dr. or Circle, The Home vs. Home, Martin Luther King vs. MLK, email address submitted incorrectly, etc.). | • LME-MCOs should review both provider self-assessments to verify the information is duplicative. If the assessments are true duplicates, and are not listed on the Validation Quarterly Report, a Master Index request can be submitted.<br>• LME-MCOs are able to request, via Master Index, an updated name and contact information for a provider. This should support with alleviating new duplicates from appearing within the system. |
| Shared Sites | • Supported employment cannot be provided out of a day support setting. Corporate site assessments can be utilized. |
| Provider staff change | Assessment # **XXXX** new contact information:<br>Email address **XXXX@XXXX** and contact name **XXXX XXXXXX** and phone number **XXX XXX-XXXX** |

**NC DHHS Home and Community Based Services (HCBS)**
**Heightened Scrutiny Process**

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

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

The State will not consider facilities that are in buildings that provide inpatient institutional treatment and those on the grounds of, or immediately adjacent to, a public institution for Heightened Scrutiny review.

The State will not consider farms and disability specific gated communities for Heightened Scrutiny review. If a setting is meeting one of the above criteria during the provider self-assessment process, the HS assessment will be conducted. Information gathered or identified in reviews may be submitted as evidence for the HS desk review.

1. Provider sites complete the provider self-assessment using the online tool. Whenever the provider selects 'yes' to any responses in **Section I: Settings That Are Not Home and Community Based, question 2**, on the provider self-assessment; the LME-MCO/DMA (CAP-DA) must initiate the HS process by requesting the Heightened Scrutiny Threshold Tool from DHHS.
2. DHHS will provide the LME-MCO/DMA (CAP/DA) with a link to the Heightened Scrutiny Threshold Tool.
3. The LME-MCO/DMA (CAP/DA) will forward the Heightened Scrutiny Threshold Tool to the provider for completion specific to the site within 10 business days.
4. Once the provider has completed the Heightened Scrutiny Threshold Tool, DHHS will provide the LME-MCO/DMA (CAP/DA) with the electronic link against which to review the provider's response.
5. LME-MCO/DMA (CAP/DA) will notify DHHS if the site meets one of the above three criteria for heightened scrutiny.

6. DHHS will conduct a desk and onsite review of sites, as appropriate, that fall within the heightened scrutiny category.
    a. The LME-MCO/DMA (CAP/DA) will gather required documents from the provider site on behalf of DHHS in preparation for the desk review DHHS will conduct prior to making its site visit, if determined necessary.
    b. Upon notification of the heightened scrutiny site, all required documents should be submitted to the HCBSTransPlan@dhhs.nc.gov by the LME-MCO/DMA via secure message within 7 business days.
    c. DHHS will conduct desk reviews within 14 calendar days of receipt of documents. If additional information is required for review of documents, DHHS will reach out to the LME-MCO/DMA and will have an additional 14 calendar days to review all documents submitted.
        i. If an onsite visit is required, DHHS will schedule it within 10 business days of the completed desk review and it will be conducted within 60 calendar days.
        ii. If it is determined an onsite visit will not be conducted, DHHS will issue a letter to the LME-MCO/DMA and the provider explaining why. The reasons may include the following:
            I. Based on the desk review, DHHS determined the site will not be able to overcome its institutional presumption, even with remediation.
            *The process will move to step 8*
            II. Based on the desk review, documentation does not support the institutional presumption. Therefore, the initial self-assessment review process will move forward.
            III. The provider has removed the site from the review process and declined to continue providing HCBS waiver services.
        iii. DHHS will conduct onsite reviews of the setting(s) accompanied by LME-MCO/DMA (CAP/DA) staff.

iv. A HS Committee will review results from the desk and onsite reviews after one or both have been completed. The committee will include DHHS and LME-MCO/DMA (CAP/DA) representation, and the review will be completed within 30 calendar days after receiving the desk review and the onsite review, if an onsite is completed.

7. Based upon the desk and onsite reviews, DHHS will make an initial determination if the site can overcome the institutional presumption or cannot overcome the institutional presumption.
   a. If DHHS determines the site *may* be able to overcome the institutional presumption, the site will undergo CMS's heightened scrutiny process. To initiate that process, DHHS:
      i. Will notify LME-MCO, Local Lead Agency (LLA), provider, individuals, and families of status and next steps.
      ii. May ask for additional plan of action steps and timelines that assist the site with becoming fully compliant with the rule. Any additional action steps and timelines requested must be submitted within 14 calendar days.
      iii. Will compile the evidence for the setting using the information/documentation gathered prior to the site review.
      iv. Will post evidence reviewed and received during the HS desk and onsite review to the DHHS HCBS website. HIPAA protected information will not be posted.
      v. Will notify public of HS public comment period for each site undergoing this process – Public notice will be posted on the state's HCBS website (https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule), posted in local newspaper, and disseminated to the LME-MCO, LLA, and HCBS stakeholder groups.
      vi. Will submit request to CMS for HS review including the site's evidence and public feedback. CMS will make the final determination of the site's HCBS site status.
   b. If DHHS determines the site cannot overcome the institutional presumption, DHHS will:

i. Notify the LME-MCO, Local Lead Agency, and DMA (CAP/DA) of next steps via written notification.
ii. Work with individuals, provider and LME-MCO/LLA/DMA to create transition plans for individuals.
iii. Participate in quarterly transition meetings/calls hosted by the LME-MCO and LLA (as applicable) until all individuals are transitioned/relocated. Transition meetings/calls will occur more frequently if needed.
iv. The provider is required to submit a quarterly report to the LME-MCO/DMA (CAP/DA) to include the following information:
    - Member Name
    - Member and LRP Notification Date
    - Transition Planning Activities
    - Providers Toured
    - Providers Yet to be Toured
    - Tentative Transition Date
    - Tentative Transition Plan
    - Official Transition Date (once Transition has taken place)
v. Quarterly reports are to be submitted within the first month of each quarter. The LME-MCO(s) will review the report, follow up accordingly and submit the report along with any additional feedback to the HCBSTransPlan@dhhs.nc.gov email.

8. Complete all transitions by March 19, 2019.

**New Business HCBS Heightened Scrutiny Sites**

A setting presumed to have the qualities of an institution cannot be determined to be compliant with the home and community-based setting regulatory requirements until it is operational and occupied by beneficiaries receiving services there. To comply with the HCBS settings regulations, requirements beyond the physical structure of the setting itself must be met. These requirements ensure that the individuals residing or receiving services in the setting experience the setting in a manner that promotes independence and community integration.

For the Heightened Scrutiny process, a new site could mean, a facility that is under new construction, a new site not open and wants to begin using Medicaid HCBS waiver services for

its individuals after March 17, 2014 or an existing site that is operational but now wants to utilize Medicaid HCBS waiver services.

As indicated in the HCBS final regulations, any setting in which services were not being provided under an approved state plan, waiver or demonstration as of March 17, 2014, must follow the regulations for HCBS settings.

**New Construction**

It was CMS' expectation that after the publication of the final regulation, stakeholders would not invest in the construction of settings that are presumed to have institutional qualities, but would instead create options that promote full community integration, per the regulatory requirements for the 1915(c) waiver program, the 1915(i) HCBS state plan option, and the 1915(k) Community First Choice state plan option, found in 42 CFR 441.301(c)(4)(i), 441.710(a)(1)(i), and 441.530(a)(1)(ii), respectively. CMS strongly encourages states to limit the growth of these settings.

DHHS recommends providers consult with the Department prior to breaking ground with the intent to provide HCBS waiver services if the following may apply:

- in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of, or immediately adjacent to, a public institution;
- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;
- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community.

DHHS cannot guarantee CMS approval as an HCBS waiver provider. The Department will review and address these situations individually.

**Non-Operational Site**

DHHS recommends providers consult with the Department prior to opening a provider site with the intent to provide HCBS waiver services if the following may apply:

- in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of, or immediately adjacent to, a public institution;
- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;
- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports, and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community. HS cannot be assessed on a site that is not operational.

DHHS cannot guarantee CMS approval as an HCBS waiver provider. The Department will address these situations individually.

**Operational Non-Waiver Sites**

Service provider sites that provide non-waiver services and wish to become a HCBS wavier provider site may be assessed for HS. Sites that meet the characteristics listed in **Section I: Settings That Are Not Home and Community Based, question 2**, on the provider self-assessment or is;

- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;
- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community.

A desk and/or onsite review may be conducted following the process outlined above. Onsite reviews and interviews will be gathered to monitor how the individuals currently served engage in the community.

## Glossary

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|---|---|
| **Duplicate Provider Self-Assessment** | As assessment containing the same site information (i.e. name, site name, location, service type, etc.) within the HCBS Database. |
| **Insufficient Status** | Non-compliant with HCBS: At least some elements conflict with the requirements of the rule. |
| **Emerging Status** | Partially Compliant HCBS: Some elements may support the requirements of HCBS rule, but not all elements are present. |
| **Full Integration Status** | All elements support the requirements of the HCBS rule. |
| **Fully Compliant Status** | Compliant with HCBS: All elements support the requirements of the HCBS rule. |
| **HCBS-Home and Community Based Services** | The Home and Community Based Services (HCBS) final rule directed the Department of Health and Human Services (DHHS) to ensure individuals receiving services through its 1915(c) waivers have full access to the benefit of community living and the opportunity to receive services in the most integrated setting possible. |
| **Heightened Scrutiny** | CMS has provided guidance that settings that meet the criteria below must go through the heightened scrutiny (HS) process to ensure the setting can overcome the presumption of having "qualities" of an institution:<br>• In a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;<br>• located in the building on the grounds of, or immediately adjacent to, a public institution; or<br>• a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. |
| **Provider Self-Assessment** | Initial tool used to make the determination if sites meet compliance with HCBS final rule. |

## Additional Resources

- NC DHHS Home and Community Based Settings (HCBS) Self-Assessment Companion Document
- NC DHHS Validation Q & A
- HCBSTransPlan@dhhs.nc.gov