

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, 2022. 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, 2022. All new sites outside of the transition period must be Full Integration/Fully Compliant PRIOR to providing services.

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HCBS Provider Self-Assessment Reviewing Entity

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

- **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.

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, 2022) 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, supply a brief description within the 'Questions' field as to the reason the assessment is being archived, notating the new assessment number, and utilizing the applicable language below. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not deleted from the system.
2. Identify the new provider self-assessment(s) for the future address and supply a brief description within the 'Questions' 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 if an item is found to be out of compliance.

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, supply a brief description within the 'Questions' field as to the reason the assessment is being archived, notating the new assessment number, and utilizing the applicable language below. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not deleted from the system.
2. Identify the new provider self-assessment(s) and supply a brief description within the 'Questions' field utilizing the applicable language below.

Language for Comments Field of Original/Current Assessment:

This assessment is being archived 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 compliance/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, supply a brief description within the 'Questions' field as to the reason the assessment is being archived, notating the new assessment number, and utilizing the applicable language below. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not deleted from the system.

Language for Comments Field of Original/Current Assessment:

This assessment is being archived 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 # XXXXXXXX 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:

- Provider Within Transition Period: 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.

County Transition

In the event DHHS has approved a county to transition from one LME/MCO to another, the DHHS HCBS Internal Team will interface with both LME/MCOs involved to complete the steps outlined below and ensure a smooth transition of HCBS Provider Self-Assessments.

1. The DHHS HCBS Internal Team will generate a report from the HCBS Database, filtered via county location in accordance with applicable zip code(s).
2. The DHHS HCBS Internal Team will reconcile and compile Validation data from the current LME/MCO's most recent reconciled Quarterly Validation Reporting tool (if applicable) to include in the report provided to LME/MCOs.
3. The DHHS HCBS Internal Team will provide the report to both the current LME/MCO and the receiving LME/MCO.
 - a. It is requested that the receiving LME/MCO hold any questions of the current LME/MCO until the current LME/MCO has had an opportunity to review the report and provide feedback.
4. The current LME/MCO will review the report and provide feedback on the information outlined below within thirty (30) calendar days.
5. The receiving LME/MCO should review the report to ensure the list reflects providers and sites that they are certain will belong to them.
 - a. Any discrepancies or questions should be directed to the DHHS HCBS Internal Team via HCBSTransPlan@dhhs.nc.gov.
6. Upon return of the report from the current LME/MCO, the DHHS HCBS Internal Team will interface with the current LME/MCO to finalize the list of transitioning sites.
7. The DHHS HCBS Internal Team will provide both the current and receiving LME/MCO with the final list for review, questions or feedback, and request final approval from both LME/MCOs within seven (7) business days.
 - a. Any discrepancies or questions should be directed to the DHHS HCBS Internal Team via HCBSTransPlan@dhhs.nc.gov.
 - b. In the event either LME/MCO is non-responsive, a reminder email will be provided allowing 2 business days to respond before the transitions will take place. Failure to respond to the email will result in the county transfers as specified by the final list and in turn, all sites listed will become the responsibility of the receiving LME/MCO.
 - i. Changes from that point forward require normal SOP procedures to be followed.
8. Upon confirmation of the final list from both LME/MCOs, the DHHS HCBS Internal Team will submit the IT request to transfer sites to the receiving LME/MCO in the HCBS Database.
 - a. Any follow up required is now the responsibility of the receiving LME/MCO.

The following information is identified on the report for any applicable LME/MCO follow-up:

- *Sites that are marked 'not accepted' (archived) in the HCBS Database and require no additional follow-up.*
- *Sites that have been submitted but have not been reviewed and are therefore not fully compliant. These require follow-up by the currently assigned LME/MCO.*
- *Site assessments that have been saved but not submitted. These require follow-up by the currently assigned LME/MCO.*
- *Duplicate addresses and potential duplicate assessments. These require follow-up by the currently assigned LME/MCO.*
- *Site assessments that have been submitted but have not been accepted and are not fully compliant. These require follow-up by the currently assigned LME/MCO.*
- *Sites that are not fully compliant. These require follow-up by the currently assigned LME/MCO.*
- *A tab dedicated to the current LME/MCO's most recent reconciled Quarterly Validation Report for reference, if needed. Note, this tab will not be viewable by the receiving LME/MCO.*

Provider Contract Termination

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** to ensure transfer of assessment.
 - i. The LME/MCO that initially reviewed the assessment will identify the responsible LME/MCO to discuss the transfer of the assessment.
 - ii. 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).
 - iii. DHHS will initiate communication with the receiving LME/MCO to confirm they are in agreement with the transfer of the assessment.
 - b. If this information is unknown to the LME/MCO, the LME/MCO would, at the bottom of the self-assessment, supply a brief description within the ‘Questions’ field as to the reason the assessment is being archived. Then, select the ‘Archive Assessment’ button. For record purposes, this assessment will be archived and not deleted from the system.

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 That Are No Longer Active

In the event that a site may be contracted with an LME/MCO or CAP-DA but not currently providing HCBS waiver services and the provider has no intent to provide waiver services in the future, the process below may be completed.

Please note, prior to archiving the assessment in this scenario, it's important the LME/MCO or CAP-DA 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.

1. Identify the provider self-assessment(s) and at the bottom of the self-assessment, supply a brief description within the 'Questions' field as to the reason the assessment is being archived, utilizing the applicable language below. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not deleted from the system.

Language for 'Questions' Field of Assessment:

After confirmation with the provider/site, this assessment is being archived 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 provide HCBS waiver services again in the future, the following applies:

- If the provider or site address have changed, a new HCBS Provider Self-Assessment is required.
- If the provider and site address remain the same, and the HCBS Provider Self-Assessment was archived more than 1 year ago, please refer to the section **Returning an Assessment to Active Status.**
- If the provider and site address remain the same, and the HCBS Provider Self-Assessment was archived less than 1 year ago, please refer to the section **Returning an Assessment to Active Status.**

Returning an Assessment to Active Status

An HCBS Provider Self-Assessment that was previously marked 'Not Accepted' (prior to the HCBS Database uplift) or 'archived' may be returned to active status in the HCBS Database under certain circumstances below.

The HCBS Provider Self-Assessment was previously assessed full integration-fully compliant with all HCBS components and was marked 'Not Accepted' or 'archived' **in error 6 months ago or less.**

1. The LME/MCO should submit the request to return the assessment to active status within the HCBS Database on a Master Index Request.
 - a. The LME/MCO should notate the reason for returning the assessment to active status and the date the assessment was marked 'Not Accepted' or archived.
2. Upon confirmation of the request, DHHS will return the assessment to active status.

The HCBS Provider Self-Assessment was previously assessed full integration-fully compliant with all HCBS components and was marked 'Not Accepted' or 'archived' **1 year ago or less.**

1. The LME/MCO should submit the request to return the assessment to active status within the HCBS Database on a Master Index Request.
 - a. The LME/MCO should notate the reason for returning the assessment to active status and the date the assessment was marked 'Not Accepted' or archived.
2. Upon confirmation of the request, DHHS will return the assessment to active status.
3. Once assessment has been returned to active status, within the 'Questions' field of the assessment, the LME/MCO will pend a question to the provider utilizing the language below to ensure all evidence previously submitted still applies and meets HCBS compliance.
4. If the LME/MCO is in agreement with the provider's response, the process is complete.

Language for 'Questions' Field of Assessment:

This assessment has been returned to active status due to XXXXXXXX. Please review each HCBS component and confirm that all evidence previously submitted still applies to the site. If there are any discrepancies, please provide updated evidence that supports HCBS compliance.

The HCBS Provider Self-Assessment was previously assessed full integration-fully compliant with all HCBS components and was marked 'Not Accepted' or 'archived' **more than 1 year ago.**

1. The LME/MCO should submit the request to return the assessment to active status within the HCBS Database on a Master Index Request.

- a. The LME/MCO should notate the reason for returning the assessment to active status and the date the assessment was marked ‘Not Accepted’ or archived.
2. Upon confirmation of the request, DHHS will return the assessment to active status.
3. Once assessment has been returned to active status, within the ‘Questions from Reviewer’ field of each HCBS component on the assessment, the LME/MCO will pend a question to the provider utilizing the language below requesting updated evidence to ensure the site meets HCBS compliance for each component.
4. The LME/MCO will remediate all HCBS components to full integration-fully compliant status.

Language for ‘Questions from Reviewer’ Field of Each HCBS Component:

This assessment has been returned to active status due to XXXXXXXX. Please review and confirm if the site meets each HCBS component. If Yes, state evidence used to support. If No, provide proposed remedial measures/plan of action.

The HCBS Provider Self-Assessment was not previously assessed full integration-fully compliant with all HCBS components prior to being marked ‘Not Accepted’ or ‘archived’.

1. The LME/MCO should submit the request to return the assessment to active status within the HCBS Database on a Master Index Request.
 - a. The LME/MCO should notate the reason for returning the assessment to active status and the date the assessment was marked ‘Not Accepted’ or archived.
2. Upon confirmation of the request, DHHS will return the assessment to active status.
3. Once assessment has been returned to active status, within the ‘Questions from Reviewer’ field of each HCBS component on the assessment, the LME/MCO will pend a question to the provider utilizing the language below requesting updated evidence to support each component.
4. The LME/MCO will remediate all HCBS components to full integration-fully compliant status.

Language for ‘Questions from Reviewer’ Field of Each HCBS Component:

This assessment has been returned to active status due to XXXXXXXX. Please review and confirm if the site meets each HCBS component. If Yes, state evidence used to support. If No, provide proposed remedial measures/plan of action.

Please note, prior to archiving the assessment, it’s important the LME/MCO or CAP-DA 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.

Updates to Demographic Information

The Demographic Information section on the HCBS Provider Self-Assessment contains information pertaining to the HCBS setting such as Provider Name, NPI#, Site Name, Site Address, HCBS Service Type, etc.

When a site requires a change or update in demographic information, the following applies:

Change Due to Change in Physical Location- Refer to section, **Provider Address Change**

Change Due to Provider Acquisition- Refer to section, **Provider Acquisition**

Change of Site Name- If ALL other Demographic Information remains the same, the LME/MCO should submit the request to update the assessment on a Master Index Request.

Change Due to Data Entry Error- If ALL other Demographic Information remains the same and the LME/MCO confirms it was a true error in data entry (i.e. 112 Trail Drive vs. 1112 Trail Drive), the LME/MCO should submit the request to update the assessment on a Master Index Request.

Change in Licensure Status- If there is a change in licensure status, the following process applies:

1. Within the ‘Questions from Reviewer’ field of each HCBS component on the assessment, the LME/MCO will send a question to the provider utilizing the language below requesting updated evidence to support each HCBS component.
2. If there are any discrepancies, the LME/MCO will remediate all HCBS components to full integration-fully compliant status.
3. If the LME/MCO is in agreement with the provider’s responses, the LME/MCO should submit the request to update the assessment on a Master Index Request.
 - a. The LME/MCO or CAP-DA should ensure the request includes applicable updates to License Type, Facility Type, and Bed Size.
4. Upon confirmation of the request and completion of the above steps, DHHS will process the update.

Language for ‘Questions from Reviewer’ Field of Each HCBS Component:

The licensure status for this site has changed. Please review and confirm if the site continues to meet compliance for each HCBS component. If Yes, state evidence used to support. If No, provide proposed remedial measures/plan of action.

Please note, any changes to Demographic Information are tracked on the Assessment History page within the HCBS Provider Self-Assessment for reference.

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 demographic information 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 self-assessment, supply a brief description within the 'Questions' field as to the reason the assessment is being archived.
 2. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not 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, supply a brief description within the 'Questions' field as to the reason the assessment is being archived.
2. Then, select the 'Archive Assessment' button. For record purposes, this assessment will be archived and not deleted from the system.

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 being archived, a brief description should be entered within the comments field as to the reason for being archived.
- 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
- [Multiple Site Guidance](#)

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 or CAP-DA's validation process as "No longer contracted with LME/MCO or 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

During reconciliation of Quarterly Validation Reporting tools, if the DHHS HCBS Internal Team identifies information within an HCBS Provider Self-Assessment that contradicts HCBS compliance for a validated setting, the site will be flagged for look-behind review.

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 or 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 or /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 or 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 or 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 receipt of site-specific documentation from all LME/MCOs or 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 or 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. In the event of any restrictions that would prevent a physical onsite monitoring visit, a desk review may be completed in lieu of an intense on-site review with a clear plan for future onsite monitoring. LME/MCOs and CAP-DA should request technical assistance from the HCBS Internal Team if this alternative is being considered.
 - ii. 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 or 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 SFTP (Secure File Transfer) or 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 or 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 or 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 and Reviewing Entity Findings”**: 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**: These are surveys which are in the process of having follow-up completed.
 - c. **Closed: Findings Unsubstantiated**: This is the status of surveys which the reviewing entity completed follow-up and determined findings were unsubstantiated or no issues were identified.
 - d. **Closed: Identified Issue(s) Resolved**: This is the status of surveys which were reviewed, follow-up was completed on identified issues, and issues were resolved.
 - e. **Closed: Unable to Process**: This is the status of surveys which were reviewed, and the reviewing entity was unable to process due to provider no longer contracted, member unable to be identified, etc. If this finding is selected, a brief comment must be provided indicating the reason it was unable to be processed.
- **“Reviewing Entity Comments”**: This section captures the specific findings or notable follow-up completed. Please provide additional details regarding the items necessitating review. A brief comment must be provided if the finding selected is ‘Unable to Process’.
- **“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	<p>LME/MCO will need to review the following for accuracy:</p> <ul style="list-style-type: none"> • Did the provider select the appropriate service? Was this attributed to a drop-down error? • Is this attributed to the site being a corporate site for supported employment or are individuals working at the site? <ul style="list-style-type: none"> ○ In the event that it is a corporate site, this should be noted on a Master Index request. • The only site that should have a corporate site representation is supported employment. All other sites should speak to where services are being provided. <ul style="list-style-type: none"> ○ 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.).	<ul style="list-style-type: none"> • 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. • 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	<ul style="list-style-type: none"> • Supported employment cannot be provided out of a day support setting. Corporate site assessments can be utilized.
Provider staff change	<p>Assessment # XXXX new contact information: Email address XXXX@XXXX and contact name XXXX XXXXXX and phone number XXX XXX-XXXX</p>

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 or CAP-DA must initiate the HS process by requesting the Heightened Scrutiny Threshold Tool from DHHS.
2. DHHS will provide the LME/MCO or CAP/DA with a link to the Heightened Scrutiny Threshold Tool.
3. The LME/MCO or 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 or CAP/DA with the electronic link against which to review the provider’s response.
5. LME/MCO or 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 or 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 or CAP/DA 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 or CAP/DA 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 or CAP/DA 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 or 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 or 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 CAP/DA of next steps via written notification.
- ii. Work with individuals, provider and LME/MCO, LLA, or CAP/DA 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 or 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 waiver 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

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	<p>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:</p> <ul style="list-style-type: none"> • In a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; • located in the 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.
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