On May 24, 2022, The Centers for Medicare, and Medicaid Services (CMS) presented a webinar "HCBS Settings Rule Implementation- Moving Forward Toward March 2023 & Beyond". During this webinar states were requested to document State and Provider compliance with regulatory criteria and submit to CMS no later than January 1, 2023. Please see The North Carolina Department of Health and Human Services response:

1. **Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations**.

   History of HCBS in North Carolina

   The North Carolina Innovations waiver program is a 1915(c) waiver. The waiver is managed by six Prepaid Inpatient Health Plans (PIHPs), which are currently referred to as Local Management Entities-Managed Care Organizations (LME-MCOs), in specified geographic areas of the State. These LME-MCOs operate under contracts with the Division of Health Benefits (DHB) for the management of Medicaid mental health, intellectual/developmental disability, and substance abuse services for beneficiaries three years old and older. They also operate under contracts with the DMH/DD/SAS for the management of State funded mental health, intellectual/developmental disability, and substance abuse services. The LME/MCOs manage their own provider networks and will continue to have direct oversight over the assessment of HCBS for their providers and monitoring activities.

   The CAP/DA waiver and its self-directed model CAP/Choice, and the CAP/C waiver are 1915(c) waivers that are operated in a Fee- for-Service (FFS). Local Case Management Entities (CMEs) provide case management and utilization management to the individuals that are served in their catchment. Division of Health Benefits (DHB) will have direct accountability over the assessment of HCBS for their providers, but the case management entities will monitor services and supports rendered by providers to the beneficiary.

   In 2012, NC DHHS transitioned to the Innovations wavier. During this transition DHHS had conversations with CMS to discuss, at that time, the "draft" HCBS Final Rule and how it could be incorporated into the waivers. At that time, NC DHHS implemented the HCBS Final Settings Rule only to licensed Residential settings. Specific areas addressed to align with the drafted settings rule were:

   - Telephone access,
   - Visitors,
   - Living Space
   - Service Customization
   - Food (access to and meals)
   - Meals
   - Storage of Food access
   - Group activities
   - Community activities
   - Community integration.

In 2012, NC waiver services were allowed on the grounds of Intermediate Care Facility (ICF-IID), Adult Care Homes (ACH), and Residential facilities larger than six beds, but classified as group homes. ACH's were removed as a provider type for the provision of implementing the 2012 Waiver services (individuals who opted to remain in ACH's were provided a choice to continuing residing in the home and receive waiver services outside of the facility). Individuals living on the grounds of ICF-IID facilities had the choice to remain in the setting and withdraw from the waiver or move to a waiver compliant site. DHHS required facilities larger than six beds to attest to meeting the HCBS characteristics outlined in the waiver to continue enrollment as a waiver provider. If a facility chose not to attest, the individual had the choice to remain in that setting and withdraw from the waiver or move to a waiver compliant site.

As a result of this history, NC DHHS began the HCBS Final Rule process with no waiver services being provided in residential settings on the grounds of ICF-IID facilities or in Adult Care Homes.

North Carolina amended the language in the Waiver applications to specify that waiver amendments or renewals will be subject to any provision or requirement included in the state's most recent and approved Statewide Transition Plan, and that HCB settings must be compliant with standards outlined in the HCBS Final settings rule. In addition, as outlined within this Statewide Transition Plan, HCBS Final Rule requirements apply to all identified HCBS settings regardless of licensure status. Regulatory requirements for HCB settings were included into the existing Innovations Waiver and CAP/DA waiver Care Coordination Monitoring Tool. This addition used existing processes set up to monitoring waiver services. It furthered the intent and expanded the scope of the monitoring tool to include HCBS settings requirements.

In 2015, NC DHHS also launched a HCBS Webpage as part of the Departments initiatives. The Home and Community Based Services Final Rule Page, included the North Carolinas Vision, Listening and Sharing Sessions, Public Notice and Request for Comment, Plan Submission, Provider Self- Assessment, and the My Individual Experience survey (NC implemented this survey for individuals and families receiving Medicaid Waiver services to report their experiences).

NC DHHS embedded the following methods into its oversight system to start compliance with HCBS Regulatory Rule. NC will continue to use these modified methods to ensure compliance with regulatory criteria into ongoing operations. LME-MCOs are a critical part of NC oversight Systems. The six LME-MCOs contract with the DHHS to provide a Medicaid delivery system in their catchment areas. Monitoring of HCBS regulatory criteria will continue through:

- LME-MCOs direct oversight of its networks and internal monitoring systems
- Provider Self Assessments
- Care Coordination Monitoring Tool
- My Individual Experience Surveys
- The NC HCBS Database
- DHHS Monitoring of the ongoing HCBS oversight systems

North Carolina's ongoing monitoring activities and functions will ensure continuous, long-term compliance to the HCBS settings regulation in Impacted and Non-Impacted Services. Efforts will

be a continuation of and incorporated in existing monitoring and performance improvement processes as outlined in this statewide transition plan.

2. Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.

Initial compliance and ongoing monitoring for continued HCBS compliance will occur through the initiation of the Provider Self-Assessment and the Validation process. The Provider Self-Assessment allows the provider to attest and provide evidence of compliance and integration with HCBS Final Rule. NC DHHS uses this method to assess the providers for compliance, identify strength and weaknesses of the HCBS delivery system, increase dialogue with the LME-MCOs about their findings, and provide technical assistance (when needed) for system improvement. The validation process confirmed the accuracy of provider self-assessments through four monitoring methods.

Provider Self-Assessments were submitted for sites that deliver:

- Residential Support
- Day Supports
- Supported Employment
- Adult Day Health services

The validation process includes four methods:

- Face to face (Care Coordination Tool)
- Desk Review of provider policy and procedures
- intense on-Site review (initiated if significant discrepancies in agency polies were presented in the provider self-assessment and Care Coordination Tool)
- Telehealth visit (approved by CMS March 2022 included for the Public Health Emergency)

Initial Compliance

DHHS collaborated with stakeholders to develop a provider self-assessment tool and a comprehensive companion guide for providers to evaluate compliance with the HCBS Final Rule. The assessment included identification of the type of setting and service provided, evidence supporting compliance with HCBS standards, and proposed remediation for standards that are out of compliance.

The LME-MCO's and CAP/DA serve as reviewing entities for the Provider Self-Assessment. Reviewing entities assessed, evaluated, and considered the initial assessments for the following

- Determined if individual provider assessments were compliant with the HCBS Final Rule
- Identified providers that needed technical assistance to ensure compliance, and
- Identified providers out of compliance and assessed their intent and capacity with technical assistance to comply

Assessments were reviewed and given a status of full integration- full Compliance, Emerging Integration-Partial Compliance, Insufficient Integration-Non-Compliant. NC DHHS chose to include the term “integration” along with ‘compliance’. This decision was to ensure ‘integration’ of the HCBS rule into the policies, procedures, and actions of the provider. The terms Full Compliance-Full Integration was used to encourage integration and ensure the HCBS philosophy becomes apart of the service system. Reviewing entities worked with providers with emerging integration-partial compliance to reach full integration-full compliance. Providers meeting full integration/full compliance moved into the next phase of validation.

Providers with Insufficient integration-non-compliant status asked of their intent to follow final rule if the provider wished to comply the reviewing entities and the DHHS provided technical assistance to support the provide in reaching full integration-full compliance. If the provider indicated they did not wish to comply, a plan of action was submitted to the reviewing entities detailing how individuals within the setting would be transferred to an HCBS compliant site.

NC DHHS provided Validation training to stakeholders that provided

- Validation question and answer,
- DHHS HCBS Review Tool,
- Care Coordination Monitoring checklist,
- Validation Training Power points,
- Example of HCBS Determination Notification.

NC DHHS HCBS Internal Team also implemented a look -behind process, serving as a secondary review of validated sites at the state level. The DHHS HCBS Internal Team reviewed a sample of LME-MCOs and CAP-DA validated provider self-assessments. Raosoft Sample Calculator sampling size selected for review was completed using Raosoft Sample Calculator. DHHS also used RatStats to determine the sample. Sampling was stratified, meaning it included all service categories. NC DHHS also developed the HCBS Standard Operating Procedure Manual and Guidance supporting the LME-MCOs and CAP/DA in HCBS compliance.

Ongoing Monitoring for Continued Compliance

North Carolina’s ongoing monitoring activities and functions will ensure continuous, long-term compliance to the HCBS settings regulation in Impacted and Non-Impacted Services. Efforts will be a continuation of and incorporated in existing monitoring and performance improvement processes as outlined in this statewide transition plan.

The NC DHHS will continue to use its oversight systems (LME-MCO’s and CAP/DA) to review for 100% compliance of new sites through utilizing the HCBS Provider Self-Assessment created during the transition period. DHB, CAP/DA staff, and the LME/MCOs will continue to require completion of an HCBS Provider Self-Assessment for all new sites. HCBS services are not allowed to begin at new sites until full integration/full compliance with the HCBS settings regulation has been determined.

Providers will submit a Provider self-assessment along with the evidence of compliance (to include the provider’s policies and procedures), to the assigned LME/MCO or DHB CAP/DA staff. The assessment includes identification of the type of setting and service provided, evidence supporting compliance with HCBS standards, and proposed remediation for standards that are out of compliance. Like the assessment process during the transition period, this will be

accomplished using a unified and consistent process with a standardized e-Review tool and companion document for evaluation of provider compliance. Ongoing monitoring will occur through the HCBS Care Coordination Monitoring tool and the My Individua Experience Survey. NC DHHS Internal Team will also complete Quality Assurance Monitoring. On a quarterly basis, the DHHS HCBS Internal Team will engage in qualify assurance activities by completing a desk review on a sample of Full Integration-Full compliant HCBS Provider Self-Assessments.

3. **Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.**

A grievance is an expression of dissatisfaction by or on behalf of an individual about any matter. Per 42 C.F.R. § 438.400; N.C.G.S. § 108D-1: An individual receiving Home and Community Based Services, or their legally responsible person has an opportunity to file a grievance. NC DHHS plans to assert a *no wrong door* approach for a grievance. NC DHHS HCBS Internal Team will provide trainings to Individuals and families on the process of reporting a provider's non-compliance with HCBS final rule. Individuals and families will be able to report non-compliance through the My Individual Experience Survey located at the bottom of the NC DHHS Survey: My Individual Experience website. Care Coordinators and Care Managers will be trained on filing a grievance on behalf of an individuals upon identification of an issue during a monitoring visit.

NC DHHS must ensure the LME-MCO establish internal grievance procedures. LME-MCOs and Local Case Management Entities grievance departments will be trained on how to identify Provider HCBS non-compliance when a grievance is filed. The HCBS database is also being updated to allow reporting of filed grievances that have been determined by reviewing entity to be a valid grievance (that will put them out of HCBS compliance). Individuals receiving HCBS through the Innovations Waiver can file grievances through their assigned LME-MCOs. Individuals receiving HCBS services through CAP-DA can file a grievance through NC Medicaid CAP DA. An LME-MCO or CAP-DA will implement and follow 42 C.F.R. § 438.400 requirements when grievances are filed. The DHHS HCBS Internal team will develop a process for reviewing samples of grievance per LME-MCOs to identify and ameliorate negative trends.