Home and Community Based Service (HCBS) Final Settings Rule Training

Two Training options to select from,
March 14th, 10:00-11:30 or
March 17th, 9:00-10:30

Agenda

Overview of the HCBS Final Rule

New Mexico's HCBS Transition Plan

- Annual Provider Assessment
- Onsite Reviews
  - Process Prior to Review
  - Overview of Audit Tools
    - Questions and Probes
  - Additional Tips
  - Follow-Up after Assessment

HCBS Final Rule Partnerships

- Managed Care Organizations
- Department of Health

HCBS Final Setting Rule Overview

- The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS requirements on January 16, 2014 with an effective date of March 17, 2023
- Focused on improving available HCBS programs and overall quality
- Compliance with this Rule impacts state reimbursement from the Federal Government
- As a first step towards determining the compliance of New Mexico's HCBS provider settings, all selected Centennial Care providers were required to complete an online survey

Final Rule Objectives

Enhanced Quality in HCBS Programs	Added Protection of Individuals receiving these services	Assurance that individuals receiving services and supports through Medicaid HCBS programs have full access to the benefits of Community Living	Access to care in the most Integrated setting	Emphasizes Personal Autonomy and Choice	Establishes more stringent rules for provider- owned or controlled residential settings

Agency Based Community Benefits

Services impacted by the Final Rule Include:

- Employment Supports (non-residential service)
- Adult Day Health (non-residential service)
- Assisted Living (residential service)

HCBS Specifics

- **Integration** in, and supports access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- **Selection by the individual** from among all settings options that are identified and documented in the person-centered service plan and are based on the individual's needs and preferences;
- Ensure individual **rights of privacy, dignity and respect**, and freedom from coercion and restraint;
- **Optimize autonomy and independence** in making life choices;
- Facilitate **choice** regarding services and who provides them; and
- **Admission, Transfer, and Discharge Rights;** Requiring that a transfer or discharge be documented in the medical record and that specific information be exchanged with the receiving provider or facility when a resident is transferred.

What does this mean to you?

- Supports for individuals to access the greater community
- Opportunities for individuals to participate in individual and group outings (shopping, church, appointments)
- Ability for individuals to seek employment
- Support for individuals to receive the same degree of access to services in the community as those not living in a HCBS setting
- Individual control over the scheduling of daily activities
- Allowance of visitors at any time and access to private areas for conversation
- Ability of individuals to come and go as they please
- Access to transportation
- Individual access to their own funds when they want

Ensuring Compliance with the Final Rule

MCO Monitoring Activities

- Incorporate HCBS Final Rule training into MCO Provider Orientation
- Joint MCO Annual Provider Trainings to provide focused education of HCBS Final Rule requirements
- Inclusion of expectations in contracting requirements
- Annual Attestation & Screening Form completion
  - MCOs will review Screening Tools
  - Initiate remediation process as applicable
- Care Coordination assessments and touchpoints are a valuable means to gather information
  - Review of Person-Centered Plan
  - Interview of member via the standardized care coordination statewide tool
  - Internal MCO Care Coordination escalation process
- Appeals and Grievances

Onsite Validation Overview

As a follow-up to the provider surveys, providers are subject to an onsite validation review

EVALUATE

Review the physical environment and the delivery of services of the provider setting to ensure compliance with the HCBS Final Setting Rule

VALIDATE

Confirm the information received in the provider survey via an in-person assessment

Care Coordination Tool

Ongoing assessments and touchpoints

STAFF INTERACTIONS

Services are provided in a 'homelike' environment- promoting interactions between participants

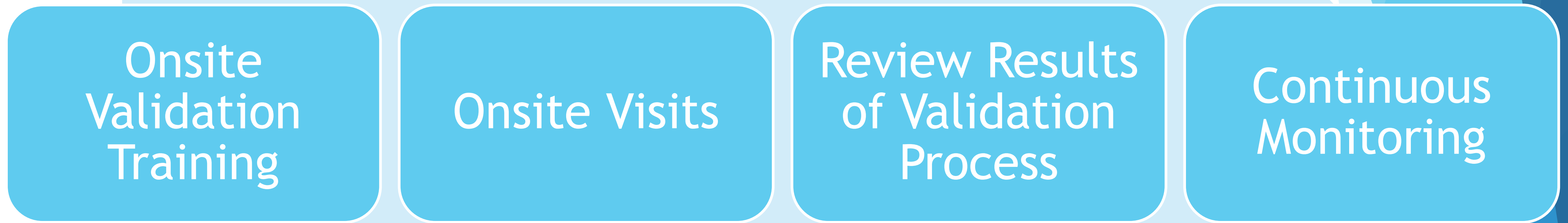
CHOICE OF CARE

Participants have a choice in the way they receive care and actively involved in the decision-making process

FLEXIBILITY

There is not a regimented schedule- there is some degree of flexibility

Onsite Validation



Onsite Visit Overview

Pre-Assessment Activities

MCO role: Provider Network sends out a letter within 30 days of scheduling an on-site visit Provider role: Provider sends available time to conduct an on-site visit with the MCO

On-Site Visit

MCO Role: Provider Network conducts MCO Provider Settings Rule assessment MCO Role: Care Coordinator conducts Member settings Rule Assessment when conducting Comprehensive Needs Assessment and during ongoing Touchpoints

Post Assessment Review/Validation

MCO Role: MCO reviews findings and sends recommendations to the Provider

Remediation/Action Provider Role

Provider develops a plan to correct issues/concerns based on the MCO's findings. Celebrate Successes

Onsite Review: Overview of Tools

Residential Settings Tool	Non-Residential Settings Tool
Assisted Living Facilities	Adult Day Health & Employment Supports

Residential Settings Tool — Assisted Living Facilities

- Choice of Residence
- Community Access and Integration
- Living Space
- Staff Interactions and Privacy
- Services

Non-Residential Settings Tool — Adult Day Health & Employment Supports

- Choice of Setting
- Community Access and Integration
- Setting Space
- Staff Interactions, Privacy and Choice

Onsite Reviews Overview of Tools

General Information Found Tool

-Reviewer name

-Date of review

-Programs in which the provider participants

-Services

  -For Providers-Services they delivery

  -For Members- Services they receive from the provider

-Services setting address

Onsite Tool

- Attestation/Screening Process occurs prior to on-site visit
- On-site Validation Tool

ANNUAL CENTENNIAL CARE AGENCY BASED COMMUNITY BENEFIT PROVIDER ATTESTATION FORM CMS FINAL RULE FOR HCBS

Please read the following summary of the Centers for Medicare and Medicaid Services (CMS) Final Rule Requirements for Home and Community Based Services (HCBS) Providers.

Any residential or non-residential provider who offers agency-based community benefit services in a setting where individuals live and/or receive HCBS must comply with the provider setting requirements. A HCBS setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

The CMS Final Rule requirements for residential and non-residential HCBS settings include:

1) **Integration in the Community**
Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:
   - Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
   - Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.

2) **Comprehensive Person-Centered Care Planning**
Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings the person-centered plan must document resources available for room and board.

Screening and Attestation

Residential Providers

1. Are there set rules or set times for when individuals can have visitors?
2. If yes, please described details:
3. Are Resident's allowed to come and go as they please? For example: Can individuals participate in unscheduled community activities such as shopping, church, visit family/friend, when they want to?
   If no, please explain:
4. How do you ensure Resident's Health information is secure and Confidential?
5. What is your process for developing an individual Plan of Care? Please address the following areas in your response:
   - Does the resident/POA have input?
   - What happens if there is a change to the Plan of Care?

Onsite Review: Post Assessment

- Each review will conclude with a closing meeting:
  - A letter will be provided by the MCOs indicating the results of the review
  - Review identified issues and the allotted timeframe to remedy in alignment with an action plan
    - Additional information may be requested as part of the action plan
  - Answer any questions regarding the review process and provide support

Next Steps: Provider Assessment Results

The appropriate compliance bucket will be determined for each provider based upon the results of the assessment/surveys and on-site validation

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Compliant	Compliant with Remediation	Presumptively Institutional	Institutional

Next Steps: Provider Assessment Results

CATEGORY 1 – Compliant

- Provider scores 100% on the provider assessment and has no remediation findings through the on-site or desk validation process
- Providers initially deemed compliant will continue to be monitored by the MCOs for ongoing compliance

CATEGORY 2 – Compliant with Remediation

- Provider scores less that 100% on the provider assessment and has some remediation findings through the on-site or desk validation processes
- Providers will be given an opportunity to remediate the issues identified. Once these are remediated, providers will move into ongoing monitoring

Next Steps: Provider Assessment Results Continued

CATEGORY 3 – Presumptively Institutional

- In the on-site assessment, observation of any of the following characteristics will result in a setting being characterized as presumptively institutional:
  - Does not provide individuals with disabilities multiple types of on-site services/activities
  - Limits integration with the broader community
  - Uses interventions or restrictions used in institutional settings or deemed unacceptable in institutional settings
- Settings in this category will be subject to heightened scrutiny review

CATEGORY 4 – Institutional- Seek HSD's Direction

It is unlikely that a setting will be immediately deemed institutional as a result of this process

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