NM Response for 1115 Centennial Care Community Benefit (HCBS)

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.

The HCBS Final Settings Rule is stated within the New Mexico Centennial Care (NMCC) contracts:

4.4.13.1.15 Members receiving the Community Benefit in HCBS settings, as defined in 42 C.F.R. § 441.301, continue receiving services using the process and/or tools prescribed by HSD.

The NMCC contracts also show the oversight of licensure and certification standards, provider manuals, and person-centered plan monitoring. The information can be found in the following Managed Care Organization (MCO) contracts: PSC 18-630-8000-0033 A5 (Blue Cross Blue Shield), PSC 18-630-8000-0034 (Presbyterian Health Plan), and PSC 18-630-8000-0035 A5 (Western Sky Community Care).

Following are excerpts from the NMCC contracts indicating the state's oversight (Section 4 CONTRACTOR's Scope of Work).

4.8.14 Standards for Credentialing and Recredentialing

4.8.14.1.11 Have written policies and procedures to ensure and verify that Providers have appropriate licenses and certifications to perform services outlined in their respective Centennial Care provider agreements;

4.8.3 CONTRACTOR Responsibility for Providers

4.8.3.1 The CONTRACTOR shall monitor all provider activities to ensure compliance with the CONTRACTOR's and the State's policies. The CONTRACTOR shall establish mechanisms to ensure that Contract Providers comply with the timely access requirements, monitor Contract Providers regularly to determine compliance and take corrective action if there is a failure to comply. The CONTRACTOR shall educate PCPs about special populations and their service needs. The CONTRACTOR shall ensure that PCPs successfully identify and refer Members to specialty Providers as Medically Necessary. 4.8.3.1 The CONTRACTOR shall ensure HCBS provider compliance with 42 C.F.R. § 441.301(c)(4), as applicable and conduct provider monitoring as directed by HSD.

4.11.3 PROVIDER WEBSITE

4.11.3.1 The CONTRACTOR shall have a provider portal on its website that is accessible to Providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider agreements, update newsletters and notifications and information about how to contact the CONTRACTOR's provider services department.

4.11.5 Provider Education, Training and Technical Assistance

4.11.5.2.3 Contract Provider education and training, which must be provided throughout the Agreement term to address clinical issues and improve the service delivery system, including but not limited to, assessments, treatment or service plans,

person-centered planning, timely access requirements, continuous quality improvement processes, discharge plans, evidence-based practices, models of care, such as integrated care and trauma-informed care;

The full view of the NMCC contract for Blue Cross Blue Shield can be found here: BCBS-2.0-Contract-PSC-18-630-8000-0033-A5.pdf (state.nm.us)

The Final Settings Rule is also included in the Community Benefit (CB) Rule (8.308.12 New Mexico Administrative Code (NMAC))

8.308.12.11 **Eligible Agency-Based Community Benefit (ABCB) Providers**
8.308.12.13.A(3) Adult Day Health
8.308.12.13.B(3) Assisted Living
8.308.12.13.B(4) Assisted Living
8.308.12.13.F(6) Employment Supports

8.308.12.15 **Eligible Self-Directed Community Benefit (SDCB) Providers**
8.308.12.18.B Customized Community Supports
8.308.12.18.D Employment Supports
8.308.12.20.E SDCB Care Plan

The full view of 8.308.12 NMAC can be found here:
https://www.srca.nm.gov/parts/title08/08.308.0012.html

The following sections of the *HSD Medical Assistance Division Managed Care Policy Manual* (10/1/20) have been updated to include the Final HCBS Settings Rule.

Section 8 Agency Based Community Benefits (ABCB)
8.3 ABCB Service Requirements (page 111):
ABCB providers must meet all Federal requirements for HCBS providers, including the Final HCBS Settings Rule. All ABCB providers must be enrolled as an active Medicaid approved provider type 363 (Community Benefit Provider) and have HSD/MAD approval to provide that service. All incomplete applications submitted to the HSD/MAD Long-Term Services and Supports Bureau (LTSSB) shall be rejected and not considered for review until a complete application is submitted.

Section 9 Self-Directed Community Benefits (SDCB)
9.9. SDCB Qualifications for all SDCB Employees, Independent Providers, Provider Agencies and Vendors (page 229):
In order to be approved as a SDCB employee, an independent provider, a provider agency (excluding Support Broker agencies, which are covered later in this document) or a vendor, each entity must meet the general and service specific qualifications found in the SDCB rules and the Manual and submit an employee agreement packet or vendor agreement packet, specific to the SDCB provider or vendor type, for approval to the FMA. SDCB providers must meet all Federal and State requirements for home and community-based providers. In order to be an authorized provider for SDCB, and receive payment for delivered services, the potential provider must complete and sign an employee agreement or vendor agreement and provide all required credentialing documents. The potential provider's credentials must be verified by the member/EOR and the FMA.

To view the entirety of Sections 8 & 9, please refer to the following link: https://www.hsd.state.nm.us/wp-content/uploads/2020/12/Centennial-Care-Managed-Care-Policy-M.pdf

HSD requires all CB providers to sign an attestation that they understand the Final Rule requirements, that settings meet the requirements of the Final Rule and that they will remain in compliance with the rule. Providers must complete the form prior to receiving HSD approval to contract with the MCOs and provide CB services. The following link provides access to the Provider Enrollment Requirement Forms and Documents page. Once there, click on the "Open File" next to *Attestation Form* to view the *Centennial Care Agency-Based Community Benefit Provider Attestation Form*.

Agency Based Community Benefits (ABCB) Program | New Mexico Human Services Department (state.nm.us)

The same attestation form is also used by the state's Fiscal Management Agent (FMA) when approving providers for participation in the SDCB program.

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

HSD provides specific language for compliance and on-going monitoring of compliance in the MCO contracts. Following is the excerpt from "Section 4.8.3 Contractor Responsibility for Providers" regarding compliance and monitoring:

4.8.3.1 The CONTRACTOR shall ensure HCBS provider compliance with 42 C.F.R. §441.301(c)(4), as applicable and conduct provider monitoring as directed by HSD.

The three MCOs have collaborated to develop an annual provider attestation form to ensure initial and ongoing compliance with the Final Rule. The form provides a summary of the CMS Final Rule Requirements for HCBS Providers. The summary includes integration into the community, comprehensive person-centered care planning, rights of privacy, dignity and respect, individual choice, tenant protections, privacy and autonomy, and admission, transfer, and discharge rights. The attestation form also provides a set of questions for residential and non-residential providers to assist them with ongoing self-assessment of their settings. A signature page is included for the provider to sign and attest they are following the Final Rule requirements. This annual attestation form is part of the MCOs' provider credentialing and recredentialing process.

The MCOs have also developed and issued a provider memo to impacted providers and will conduct regular and periodic trainings on Final Rule requirements for providers beginning in early 2023.

HSD holds monthly Long-Term Care Workgroup meetings with the MCOs and uses this forum to discuss and monitor MCO activities related to the Final Rule. HSD requires the MCOs to provide the state with regular updates through reporting on their Final Rule monitoring processes and any identified concerns with specific settings as they are identified.

HSD also monitors MCO activities through quarterly service plan audits, quality measures, performance improvement projects, established reporting processes, and by tracking member concerns.

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

The following sections within the MCO contracts (see link above) require MCO care coordinators to help ensure that settings are following the Final HCBS Settings Rule:

4.4.12.16.16 Evaluation and management of risk, including reporting Critical Incidents;

4.4.13.1.15 Members receiving the Community Benefit in HCBS settings, as defined in 42 C.F.R. § 441.301, continue receiving services using the process and/or tools prescribed by HSD.

4.4.13.2.1 The CONTRACTOR shall ensure that care coordination activities are occurring timely and are meeting the following performance standards on a quarterly basis

The MCO Member Handbook provides all Members with grievance and appeal information and the MCOs must have policies and procedures in place regarding Member grievances and appeals. HSD reviews and approves all published Member Handbooks.

4.14.3.1.14 Provide information regarding Grievances, Appeals and Fair Hearing procedures and time frames, including all pertinent information provided in 42 C.F.R. § 438.400 through § 438.424;

4.14.4.2.10 Voice Grievances about the care provided by the CONTRACTOR and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation.

4.16.2 Grievances
A Member may file a Grievance either verbally or in writing with the CONTRACTOR at any time from the date the dissatisfaction occurred. The Representative or a provider acting on behalf of the Member and with the Member's written consent has the right to file a Grievance on behalf of the Member.

4.16.2.1 Within five (5) Business Days of receipt of the Grievance, the CONTRACTOR shall provide the Grievant with written notice that the Grievance has been received and the expected date of its resolution.

4.16.2.2 The CONTRACTOR shall complete the investigation and final resolution Process for Grievances within thirty (30) Calendar Days of the date the Grievance is received by the CONTRACTOR or as expeditiously as the

Member's health condition requires and shall include a resolution letter to the Grievant.

The NMAC also states that all care coordinators must comply with all state and federal requirements. All MCO care coordinators receive at a minimum, annual training on the HCBS Settings Rule and how to identify and escalate Member concerns.

8.308.12.7 DEFINITIONS:
E. Care coordinator: The care coordinator provides care coordination activities that comply with all state and federal requirements. This includes but is not limited to: assigning an appropriate care coordination level; performing a CNA a minimum of annually to determine physical, behavioral and long-term care needs; developing a comprehensive care plan and budget based on those needs; and delivering on-going care coordination services based on the member's assessed need and in accordance with the care plan and contractual obligations.

Please reference the link above to access the full 8.308.12 NMAC document.

The Medicaid Quality Bureau monitors MCO care coordination functions to ensure compliance with contract and rule requirements through reporting and audits.

Beneficiary recourse for notification of non-compliance begins with the member's assigned MCO care coordinator. As the public health emergency begins to wind down, the MCOs have been directed to resume in-person care coordination with their members. During these visits, care coordinators assess settings and identify any member concerns using established MCO processes. Beneficiaries can also reach out to their care coordinator through their preferred method at any time to report concerns. The MCOs will report any identified issues immediately to the state through their HSD contract manager. They will also bring any issues regarding non-compliance to the monthly Long-Term Care Workgroup meetings. The MCOs and HSD will discuss issues, trends, and/or general beneficiary feedback during this meeting.

NM Response for 1915c Home and Community Based Services (HCBS) waivers

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.

The state's oversight system for the 1915 c HCBS waivers lies with the Department of Health Division of Health Improvement (DOH/DHI). The DHI survey tool was revised in 2016 and implemented during its routine provider surveys beginning in 2017 to ensure on-going compliance by CCS and residential settings: individual, privately owned residences and other presumed compliant settings in the DD Waiver DHI will conduct surveys of providers once every three years or sooner, as determined necessary. This is done by state staff, face-to-face. The DHI survey tool is a separate auditing tool created by and used by the DOH, Division of Health Improvement, Quality Management Bureau to ensure overall program requirements and standards are being followed. This tool now includes monitoring questions specific to the settings requirements. DOH also plans to initiate DHI surveys for Mi Via vendors in the next Fiscal Year.

Survey Tools:

https://www.nmhealth.org/about/dhi/cbp/qmb/ddws/tools/

Case managers and consultants also monitor individuals' experience and service settings compliance during regularly scheduled visits with the individuals. All case manager/consultant monitoring tools have been revised to include specific prompts and questions related to the settings requirements in order to facilitate monitoring for on-going compliance. Site visits are required to occur at all settings throughout the year, to include congregate day settings as applicable. The individual's person-centered service plan will be updated as needed and team meetings convened to address any identified issues and follow up activities required with providers at specific settings.

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

The Department of Health, Division of Health Improvement Quality Management Bureau (DOH/DHI/QMB) staff has ongoing monitoring responsibilities for the DDW program. Additionally, the DOH will continuously monitor settings compliance through the State's provider enrollment process, specifically through the initial and renewal application process and through the provider agreement between approved providers and the DOH as part of the ongoing provider agreement processes.

On-going monitoring of HCBS settings will include monitoring individual's private or family homes where participants reside in order to ensure the setting is integrated and compliant. DDW and Medically Fragile waiver case managers are required to conduct one site visit annually at the location where the waiver participant lives. This is documented in the case management Site Visit form.

Under Mi Via, consultants are required to conduct at least 6 face-to-face visits annually at the setting where the waiver participant lives. This visit is documented on the In-Person Update Form. For Mi Via, the DOH and Human Services Department, Medical Assistance Division (HSD/MAD) will monitor and approve settings compliance through monitoring activities that may include: face to face visits at settings, participant complaints, fair hearing requests, vendor attestations, approved by the DOH for each setting per agency, waiver quality assurance monitoring activities, and Service and Support Plan (SSP) reviews. The intent of the processes is to potentially identify areas of concern related to settings. As applicable, this type of monitoring/information gathering will provide Developmental Disabilities Supports Division (DDSD)/HSD an opportunity to provide guidance and technical assistance related to settings requirements. There are existing, additional mechanisms to gain information about possible issues with settings.

Developmental Disabilities Waiver Site Visit Tool:

https://www.nmhealth.org/publication/view/form/4736/

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

Beneficiary recourse for notification of non-compliance begins with the waiver participant's case manager/consultant. As the public health emergency begins to wind down, the case managers and consultants have been directed to resume in-person care coordination with their participants. The case managers/consultants will report any identified issues immediately to the state through either their DOH state program manager or DOH regional office. A beneficiary can directly contact the DOH. The beneficiary may contact the HSD who will then make a referral to the DOH on behalf of the beneficiary. Beneficiaries are provided information of this process during initial meetings with the case manager/consultant. Information is outlined in waiver service standards which are available to all beneficiaries, case managers/consultants, and providers. Information on these processes are also available at the DOH website at: https://www.nmhealth.org/about/ddsd/

Reporting is done through the DDSD Regional Office Request for Assistance (RORA) system. The RORA form is intended to be a helpful mechanism for informing DOH DDSD of gaps in services and/or needs for assistance. DDSD will review all submitted RORAs in a timely fashion then strategically employ assistance as necessary. A RORA form may be used to inform the state about a wide range of issues, including broad system level issues, issues related to a specific provider agency and/or issues related to a specific individual served. Anyone, including beneficiaries, are also able to utilize the RORA system and file reports on any issues they are experiencing or request assistance. The RORA form is available on the DOH website at https://app.smartsheet.com/b/form/e1352b0c7c7f4e27b09a2974538dc925

Oversight of the RORA system lies solely with the DOH. DOH is required to respond in thirty (30) days of filing for a RORA depending on the nature of the concern. Notification is sent to the filer of the RORA upon completion of review and closure of case.

As part of our process for continued improvement to established processes, DDSD began regular health and wellness checks with waiver participants in 2023. With an unprecedented home visit initiative, every person receiving supports through our home and community-based services waivers received a face-to-face visit by state staff. Regular visiting frequencies are being established with DOH staff as one mechanism for improving beneficiary feedback. Additionally, the DOH is partnering with our Public Health Division to establish a friendly face visiting program utilizing Community Health Workers. The goal of these visits is to provide increase support and oversight by health and safety checks; to provide ombudsman services and assistance with reporting; observe peoples' ability to self-direct; assess support networks and availability of community resources; and monitor settings requirements.