Developmental Disabilities Administration

Community Settings Rule-Ongoing Implementation Guidance

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Audience

- Coordinators of Community Services (CCS)
- Developmental Disabilities Administration (DDA) Medicaid Providers
- DDA Regional Office (RO) staff
- DDA Headquarters (HQ) staff.

Purpose

This guidance outlines the Developmental Disabilities Administration (DDA) Community Settings Rule (CSR) implementation strategies to ensure ongoing compliance with the Center for Medicare and Medicaid Services (CMS) Home & Community Settings Final Rule including:

- Completion of the Community Setting Questionnaire (CSQ);
- DDA RO validation of the CSQ;
- Site visits; and
- DDA and OLTSS Remediation strategies.

Home and Community-Based Final Rule

42 Code of Federal Regulations (CFR) § 441.530 Home and Community-Based Setting includes:

(a) States must make available attendant services and support in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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.

(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.[1]

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportional to the specific assessed need.

(5) Include regulation collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and support will cause no harm to the individual.

(2) Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital providing long-term care services; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary.

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[1] https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

DEFINITIONS

A. “Community Settings Questionnaire” (CSQ) is a document used as part of the Person-Centered Planning process to assess the extent to which a participant is afforded the right to make their own choices and be fully integrated in their community to the extent they wish.

B. “Coordinator of Community Services” or “CCS” is an individual who provides Coordination of Community Services. They can be either an employee or a contractor of a DDA provider.

C. “DDA” is the Developmental Disabilities Administration.

D. “DDA Medicaid Waiver program” refers to the three Medicaid Home and Community-Based Waiver programs operated by the Developmental Disabilities Administration (DDA) that serve eligible children and adults with intellectual and developmental disabilities. These programs are approved by the Centers for Medicare & Medicaid Services and include the:

1. Family Supports Waiver.
2. Community Pathways Waiver;
3. Community Supports Waiver; and

E. “DDA Medicaid Provider” is an individual or entity, licensed or certified by the Maryland Department of Health, that provides DDA-funded services to applicant(s) or participant(s) according to the DDA’s requirements.

F. "Federal Home and Community-Based Settings Final Rule" is a rule provided by CMS that supports enhanced quality in HCBS programs, adds protections for individuals receiving

services, and promotes full access to community life, including providing opportunities to seek employment and work in competitive, integrated settings.

G. "Home and Community-Based Services" or "HCBS" are types of person-centered services delivered in the home and community. HCBS programs provide assistance to people with functional limitations with everyday activities and support people to stay in their homes, rather than moving to an institutional-like setting for care.

H. "LTSS*Maryland*" is an electronic information system, developed and supported by the Department. It is used by the DDA, the CCS, and DDA Providers to create, review, and maintain records about:

1. An individual's eligibility status for DDA-funded services; and
2. The individual's person-centered plan, and services and funding authorized by the DDA.

I. "Non-Residential Setting" is a site or location in which waiver services are rendered and the setting is not a home or living space in which a waiver participant resides.

J. "Non-Residential DDA Licensed Setting" is a site or location which is operated by a DDA MA provider and licensed by the OHCQ to render waiver services and a day setting. This setting is not a home or living space where a waiver participant resides.

K. "Office of Long-Term Services and Supports" (OLTSS) is the Maryland Department of Health Medicaid office.

L. "Office of Health Care Quality" (OHCQ) is the Maryland Department of Health department that licenses providers and sites on behalf of the DDA.

M. "Participant" is an individual who receives DDA-funded services.

N. "Program Service Plan" is a required document(s) as part of the DDA Medicaid Provider application and renewal process that details how a provider will deliver each of the services they are applying to render. This includes rationale and a discussion of the applicant's philosophy for the provision of services, scope of the services, staffing and training, and the setting and location of the services.

O. "Provider Services" (PS) is as related to their role in the CSR, PS is comprised of DDA staff who work together with DDA providers and DDA provider applicants to establish, maintain, and implement policies and practices of a person-centered delivery system of waiver services for participants in settings to meet the CSR. PS also dis-enrolls providers' non-CSR compliant sites in Maryland's MA program.

P. “Regional Office" (RO) is one of the DDA’s four local offices. ROs are the point of contact for applicants, participants, families and DDA providers living and working in the counties they serve. Each RO has the authority to review individual Person-Centered Plans and approve funding for services. The Regional Offices include the:

1. Central Maryland Regional Office, serving Anne Arundel, Baltimore, Howard, and Harford Counties and Baltimore City;

2. Eastern Shore Regional Office, serving Caroline, Cecil, Dorchester, Kent, Queen Anne’s, Somerset, Talbot, Wicomico, and Worcester Counties;

3. Southern Maryland Regional Office, serving Calvert, Charles, Montgomery, Prince George’s, and St. Mary’s Counties; and

4. Western Maryland Regional Office, serving Allegany, Carroll, Frederick, Garrett, and Washington Counties.

Q. “Residential Setting” is a home or living space which may or may not be provider operated, such as a:

1. Community living group home;

2. Family home;

3. Apartment: or

4. Another residence where a waiver participant resides and receives waiver services.

R. “Residential DDA Licensed Setting” is a home or living unit operated by a DDA MA provider which has been licensed by the OHCQ and which community living group home services are funded for a waiver participant.

OVERVIEW

A. The Federal Home and Community-Based Settings Final Rule ensures that:

1. All HCBS waiver participants are able to make choices in all aspects of their lives; the same as a peer without a developmental disability would experience; and

2. Participants are able to participate and integrate into their broader communities to the extent they wish.

B. The DDA, in collaboration with CCSs, DDA Medicaid providers, and OLTSS, works to ensure ongoing compliance across all DDA Medicaid settings as outlined below .

C. This collaboration will include the completion of the CSQ, RO validation of the CSQ, site visits, and applicable remediation strategies both at the DDA RO, HQ, and OLTSS as necessary.

Applicability

This guidance applies to Residential/Non-Residential DDA Settings including:

A. New DDA Medicaid providers/sites;

B. New DDA Medicaid sites and capacity increases for existing DDA Medicaid providers; and

C. Existing DDA Medicaid providers and sites.

New DDA Medicaid Providers

All new DDA Medicaid Providers must be in compliance with the Federal Home and Community-Based Settings Rule at the time of application approval and prior to providing services.

A. Program Service Plans and policies and procedures submitted as required as part of the DDA Provider Application packet must detail how the provider will ensure participants receive choices in all aspects of their services as well as how they will be integrated into their broader communities. The RO will provide a list of policies that should address the CSR questions from the Non-Residential Site Validation and Residential Site Validation tools.

B. RO PS staff will review the submitted documents in the order in which they are received and, should the packet not detail these items for each service, the applicant will be denied and issued a denial letter, referencing the specific reasons for the denial.

C. Denied applicants are able to reapply at any time and/or exercise their appeal rights as outlined in the denial letter.

New DDA Medicaid Sites and Capacity Increases for Existing DDA Medicaid Providers

All new residential and non-residential sites being opened by existing providers must be determined compliant with the Federal Home and Community-Based Settings Rule prior to licensing with the OHCQ. In addition, any existing site seeking to request a capacity increase for a site must also be found in compliance prior to completing the OHCQ licensing process.

A. Providers must notify their RO PS liaison via email once they have obtained property for a new site or have completed the DDA Addendum Application for a Current Licensee for a capacity increase for an existing site.

B. RO PS staff will:

1. Schedule a time to visit the site and complete a New Site Inspection Form within 14 business days;

2. Along with email confirmation of the visit date and time, send the New Site Inspection Form ahead of time to the provider in order to prepare for the visit;

3. Upon completion of the visit, save a copy of the completed form in the provider's folder in the DDA Google Shared Drive.

C. If the new site is being licensed for an emergency placement, the provider should contact their RO Provider Services Director via email to request expedition of the new site visit inspection process.

D. Non-Compliant Sites

1. PS staff will provide technical assistance, as necessary, to ensure resolution in order for the site to move forward with licensure. Technical assistance may include sharing applicable examples, reviewing the New Site Visit CSR inspection document with the provider, review of policies and procedures with the provider, etc.

2. Each RO will document compliance using the Statewide New Site and CSR Compliance Tracker document in the DDA Google Shared Drive.

3. Following successful completion of the new site visit, RO PS Staff will forward the compliant New Site Inspection Form, along with the DDA Addendum Application for a Current Licensee to OHCQ to begin the site licensure process. Sites must be in compliance prior to submission to OHCQ. The RO will send the completed pack to OHCQ within 14 business days of completion.

NOTE: If a person(s) has already been identified to move to the new site, the DDA will still complete the New Site Inspection Form. See the following section for the CSQ completion process when a person moves to a new residential or non-residential site.

Existing DDA Medicaid Providers and Sites

All DDA Medicaid providers and sites must be in compliance with the Federal Home and Community-Based Settings Rule by March 17, 2023 and ongoing.

A. The CCS will:

1. By the person's annual PCP Annual Plan Date (APD) or within 30 days of a person moving to a new residential or non-residential site;

2. The CCS's site visit should be coordinated and planned with the site manager or supervisor and the findings discussed afterward;

3. The site manager or supervisor should ensure applicable documentation is available to assist the CCS in completing the CSQ such as the lease agreement, provider logs, activity notes, and other resources as recommended in DDA's Coordination of Community Services CSQ Guide;

4. Upon completion, the CCS will discuss their findings, including whether or not the setting was determined compliant or preliminarily non-compliant with the site manager or supervisor and enter the CSQ into LTSS*Maryland*. A non-compliant CSQ should not hold up approval/processing of, nor stop the submission of a PCP. *(DDA is working on enhancing LTSS functionality to ensure this happens automatically. In the meantime, if a CSQ is completed and it is non-compliant, and it is at risk of holding up approval/processing of a PCP, the Statewide Director of Provider Services should be notified immediately to ensure validation is expedited).*

5. As applicable or requested by provider agency leadership, the supervisor or site manager will communicate CSQ results with applicable management team members in their organization.

B. The Statewide Director of Provider Services shall:

1. Pull CSQ compliance data every two weeks in preparation for review.

2. Bi-weekly data will be saved in the Google Shared Drive in the Provider Services Statewide Drive in the Bi-Weekly CSQ Data folder, labeled with the month/day/year of data pull.

C. CSQ Validation Committee

1. All non-compliant CSQs from the most recent data pull will be reviewed every two weeks by the CSQ Validation Committee.

2. The committee will be chaired by the Statewide Director of Provider Services and consist of the Provider Services Director from each region and one additional RO staff as identified by the Regional Director.

3. The committee will complete a dual track review of all non-compliant CSQs.

    a. During each committee meeting, the team will review the previous meetings of non-compliant CSQs and their status. The regional PS Director takes the lead on gathering any necessary follow-up information for the committee to consider when

making final determination (*i.e.*, policies and procedures, documentation showing successful remediation, etc).

   b. In addition, the committee will review the new data sets pulled that will need to be followed-up on during the next review period.

   c. The committee will also consider expedited review requests to ensure completion and process of a person's PCP. Expedited requests can be made in the event a person is moving to a new home or day program and the PCP needs to be assigned in LTSS*Maryland*.

4. All CSQ Validation Committee agendas and minutes can be found in the Google Shared Drive in the Provider Services Statewide Drive CSQ Validation Committee minutes folder.

D. Validated CSQ

1. Should a CSQ be validated as compliant during this review, the CCS will be asked by the PS Liaison to complete a new CSQ in LTSS*Maryland* to reflect the revision within 14 business days.

E. Non-compliant CSQ

1. If validated as non-compliant, the PS liaison will provide applicable technical assistance to the provider to ensure compliance. If the provided TA results in a compliant result, the PS Liaison will ask the CCS to complete a new CSQ in LTSS*Maryland* to reflect the change within 14 business days. For any necessary CSQ revision, the CCS is able to complete a desk update versus starting the CSQ process from the beginning.

F. Tracking and Monitoring

1. PS team will track and monitor initial area of non-compliance and document TA provided using the Statewide New Site and CSR Compliance Tracker to identify statewide trends.

2. Monthly, the DDA Statewide Director of Provider Services shall pull a CSQ non-compliance data report for review and will cross check with regional initial non-compliance tracking to identify any inconsistencies

G. DDA Statewide Director of Provider Services shall validate CSQ non-compliance data against the data reviewed by the committee in the previous month to ensure accuracy and send to OLTSS via a shared document for review and processing

H. OLTSS will receive non-compliance data from DDA and issue non-compliance letters via email within 30 days of receipt of the information.

I. Providers will then have 30 days from receipt of the letter to remediate the area of non-compliance and DDA, along with Medicaid, will offer support and technical assistance as necessary to assist the provider in coming into compliance.

Resources

COMAR 10.09.36. General Medical Assistance Provider Participation Criteria

COMAR 10.09.36.03-1. Conditions for Participation — Home and Community-Based Settings

DDA CSR Ongoing Implementation Process Flow

Community Settings Questionnaire Manual

HCBS Final Rule CMS Website

HCBS Overview

HCBS Provider Requirements

HCBS Toolkit