Statewide Transition Plan for Compliance with Home and Community-Based Settings Requirements (Final Rule)

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EXECUTIVE SUMMARY

Maryland receives funding from the Centers for Medicare and Medicaid Services (CMS) to assist in providing home and community-based services (HCBS) through the Autism, Brain Injury, Community Pathways, Community Supports, Family Supports, Home and Community-Based Options, Model, and Medical Day Services Waivers as well as three (3) State Plan programs and an 1115 demonstration waiver. In 2014, the federal government established new regulations that states must follow related to the settings in which HCBS are delivered. This plan provides information about the new regulations, Maryland's review of its HCBS programs and its plan to implement the new regulations, and input received from various stakeholders (e.g., participants, participants' family members, advocates) about Maryland's plan.

INTRODUCTION

On March 17, 2014, the CMS issued regulations that define the settings in which states can pay for Medicaid HCBS, hereafter referred to as the Final Rule. The purpose of these regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated and that support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as individuals who do not receive HCBS. These changes will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting.

States must ensure all home and community-based (HCB) settings comply with the new requirements by completing an assessment of settings to ensure they comply with HCB settings requirements and existing state rules, regulations, standards, policies, licensing requirements, and other provider requirements. States must be in full compliance with the federal requirements by the time frame approved in the Statewide Transition Plan (STP), but no later than March 17, 2023.

Prior to the Final Rule, setting requirements were based on location, geography, or physical characteristics. The requirements are now defined as more process and outcome-oriented, guided by the participants' person-centered service plan, and provide clarity on the settings in which HCBS cannot be provided. These settings include nursing facilities (NF), institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), and hospitals.

The STP covers three (3) major areas: assessment, proposed remediation strategies, and public input. It identifies the framework and strategy for achieving and maintaining compliance with the federal requirements for HCB settings in Maryland.

<u>Overview of Setting Provision</u>

HCB settings must meet certain criteria. These requirements include:

- The setting is integrated in and supports full access to the greater community;
- The setting is selected by the individual from among setting options;
- The individual's rights to privacy, dignity, respect, and freedom from coercion and restraint are upheld;
- The individual has independence in making life choices; and

- The individual has a choice regarding services and who provides them.

Provider-owned or controlled residential settings must meet the following additional requirements:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- Individuals must have privacy in their living unit including lockable doors;
- Individuals sharing a living unit must have choice of roommates;
- Individuals must be allowed to furnish or decorate their own sleeping and living areas;
- The individual controls his/her own schedule, including having access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Changes to the requirements of a residential setting must be supported by a specific assessed need, which is detailed in the participant's person-centered service plan. More specifically, all of the following are required and must be documented:

- Identification of a specific and individualized assessed need;
- The positive interventions and supports used prior to any modification(s) to the person-centered plan;
- Less intrusive methods of meeting the need that have been tried, but did not work;
- A clear description of the condition(s) that is/are directly proportionate to the specific assessed need;
- Review of data to measure the ongoing effectiveness of the modification(s);
- Established time frames for periodic reviews to determine if the modification(s) is/are still necessary or can be terminated;
- Informed consent of the individual; and
- An assurance that interventions and supports will cause no harm to the individual.

Heightened Scrutiny Settings

As outlined by the CMS, heightened scrutiny reviews are applicable to residential or non-residential settings presumed to have qualities of an institution, settings located on the grounds of, or immediately adjacent to, a public or private institution that provides inpatient treatment, or settings that have the characteristics of isolating individuals receiving Medicaid HCBS from the broader community.

In accordance with the CMS' Heightened Scrutiny State Medicaid Letter #19-001 (March 22, 2019), the CMS takes the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities[1] for interaction in and with the broader

[1] "Opportunities," as well as identified supports to provide access to and participation in the broader community, should be reflected in both individuals' person-centered service plans and the policies and practices of the setting in accordance with 42 CFR 441.301(c)(1)-(3) and (4)(vi)(F), 42 CFR 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR 441.710(a)(1)(vi)(F) and 441.725.

community, including with individuals not receiving Medicaid-funded HCBS;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting;
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan; or
- The setting is located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment.

The MDH identified provider sites that appear to have institutional qualities or appear to be isolating individuals from the community, but have been determined by the MDH to meet the HCB settings requirements. The MDH's heightened scrutiny reviews consist of:

- A review of person-centered service plans and community setting questionnaires (CSQ) for individuals receiving services in the setting;
- Interviews with participants receiving services in the setting;
- A review of data pertaining to services utilized by participants receiving services in the specified setting;
- An on-site visit and assessment of the physical location and practices;
- A review of policies and other applicable service-related documents;
- A review of the provider's proposed transition plan, including how each of the above is expected to be impacted as the plan is implemented;
- A determination regarding 1) whether the setting is in fact "presumed to have the qualities of an institution" as defined in the Final Rule, and 2) whether the presumption is overcome based on evidence; and
- A collection of evidence to submit to the CMS to demonstrate compliance.

Also in conjunction with guidance from the CMS, settings located in rural areas are not automatically presumed to have qualities of an institution, and more specifically, are not considered by the CMS as automatically isolating to individuals receiving HCBS. The MDH will only submit a specific site to the CMS for a heightened scrutiny review if the site has been identified as having qualities of an institution and if the state believes that the site can overcome the presumption. With respect to determining whether a rural setting may be isolating to individuals receiving HCBS, the MDH will compare the access to the community for individuals living in the same geographical area, but not receiving Medicaid HCBS, to the access had by individuals receiving Medicaid HCBS in that area.

MARYLAND'S HOME AND COMMUNITY-BASED SERVICES

As the single state Medicaid agency, the MDH, is responsible for all 1915(c), 1915(i), 1915(k), 1915(j), and 1115 demonstration programs. The Office of Long Term Services and Supports (OLTSS) within Maryland Medicaid has administrative authority over all 1915(c), 1915(k) and 1915(j) HCBS programs and for some programs, is also responsible for daily operations. Other offices with Maryland Medicaid have administrative authority over the 1915(i) and 1115 demonstration programs. The Developmental Disabilities Administration (DDA) within MDH operates the Community Pathways, Community Supports, and Family Supports Waivers while the Behavioral Health Administration (BHA) within the MDH and the Maryland State Department of Education (MSDE) operate the Brain Injury Waiver and Autism Waiver respectively.

Maryland's home and community-based 1915(c) Waiver, 1915(i), 1915(k), and 1915(j) State Plan programs, and its 1115 demonstration waiver differ significantly with respect to the populations supported, their size, services, provider qualifications, and complexities, and the statutory and regulatory structures undergirding the programs. Each program supports individuals to receive services in the community with the same degree of access as individuals who are not receiving Medicaid

HCBS. Each HCBS program includes the following goals:

- Services must optimize individual initiative, autonomy, and independence in making life choices;
- Services must support opportunities for individuals to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
- Services must ensure individuals' rights' of privacy, dignity, respect, and freedom from coercion and restraint.

Individuals in each 1915(c) Waiver, State Plan, or demonstration waiver program must have a person-centered service plan that is based on the individual's needs and preferences, choice regarding the type and provider of services, and residential settings. Information regarding the types of services and setting options, including non-disability specific settings and an option for a private unit in a residential setting, must also be documented in the plan. Maryland maintains a comprehensive quality plan for each 1915(c) Waiver to monitor service delivery and ensure continuous compliance with HCB settings criteria. These plans include performance measures established to evaluate compliance with the various assurances and sub-assurances associated with a 1915(c) Waiver program, including ensuring the quality of person-centered service plans and assuring participants' health and welfare in the community.

The following programs are included in the STP:

Federal Reference	Program	Administering Agency	Number of Participants	Medicaid Providers
MD.0339	Autism Waiver	MSDE	1,266	68
	Community First Choice	OLTSS	9,935	975
MD.0023	Community Pathways Waiver	DDA	15,339	232
	Community Personal Assistance Services	OLTSS	509	975
MD.1506	Community Supports Waiver	DDA	1,057	203
MD.1466	Family Supports Waiver	DDA	320	58
MD.0265	Home and Community-Based Options Waiver	OLTSS	4,270	1,302
	Increased Community Services	OLTSS	23	840
MD.0645	Medical Day Care Services Waiver	OLTSS	3,650	109
MD.40118	Model Waiver	OLTSS	211	53
MD.40198	Brain Injury Waiver	BHA	110	5
	1915(i) State Plan Home and Community-Based Services (Intensive Behavioral Health Services for Children, Youth, and Families)	BHA	43	16

Note: The above are based on data from FY2021.

Maryland's STP identifies, at a high level, the commitments and requirements that each of the eight (8) HCBS 1915(c) Waivers, three (3) State Plan programs, and the 1115 demonstration waiver will meet. The specific approach and details surrounding each program is reflective of the input and guidance of the particular

program's stakeholders, and the unique structure and organization of the program itself. Similarly, the complexity of each task within the STP varies significantly across programs. Please note however, Community First Choice, Community Personal Assistance Services, Increased Community Services, and the 1915(i) listed on this page, are HCB programs that were compliant when established and are not a part of the transition plan.

The following section includes summaries of the initial findings for each program based on: an assessment of each program's provider data and a review of each program's relevant service definitions, policies and procedures within its waiver application and state regulations. The program summaries and initial findings were used to identify areas of concern, which are reflected in Maryland's proposed remediation strategies and include quality assurance processes to ensure ongoing compliance. Maryland is committed to engaging with stakeholders and has sought public input from various sources including participants, participants' family members, and advocates throughout the development of the STP.

Individuals who are enrolled in and receiving services from one of Maryland's HCBS programs may also be referred to, in this STP, as participants, children, or individuals. Similarly, person-centered service plans may also be referred to, in this STP, as individual plans, plans of care, plans of service (POS), person-centered plans of service, individualized treatment plans and individualized education plans (IEP). Finally, case managers may also be referred to, in this STP, as Supports Planners, Service Coordinators, and Coordinators of Community Services.

ASSESSMENT OF STATE REGULATIONS

As part of the STP, Maryland has made changes to Code of Maryland Regulations (COMAR) 10.09.36, which describe the requirements for provider participation in the Medicaid program. All enrolled Medicaid providers of HCBS are obligated to follow the HCB settings requirements set forth under COMAR 10.09.36. These regulations ensure full and ongoing compliance for all applicable providers and help to realize the intent of the transition, which is to ensure that individuals receive Medicaid HCBS in settings that are integrated in, and support full access to, the greater community.

COMAR	Title	Preliminary Findings	Reference
10.07.05	Residential Services Agency	Missing criteria dictated by the Final Rule and there are some areas in which the regulations conflict with requirements of the Final Rule	Appendix A
10.07.14	Assisted Living Programs	Missing criteria dictated by the Final Rule and there are some areas in which the regulations conflict with requirements of the Final Rule	Appendix B
10.09.07	Medical Day Care Services	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix C

10.09.61	Medical Day Care Services Waiver	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix C
10.09.26	Community Based Services for Developmentally Disabled Individuals Pursuant to a 1915(c) Waiver	Missing criteria dictated by the Final Rule and there are some areas in which the regulations conflict with requirements of the Final Rule	Appendix D
10.09.27	Home Care for Disabled Children Under a Model Waiver	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix E
10.09.46	Home and Community-Based Services Waiver for Individuals with Brain Injury	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix F
10.09.54	Home and Community-Based Options Waiver	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix G
32.03.01	Senior Citizen Activities Centers Capital Improvement Grants	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix G
10.09.56	Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix H

10.09.89	1915(i) Intensive Behavioral Health Services for Children, Youth, and Families	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix I
10.12.04	Day Care for the Elderly and Adults with a Medical Disability	Missing criteria dictated by the Final Rule, but there are no areas in which the regulations conflict with the Final Rule	Appendix J
10.22.01 -10.22.12 and 10.22.14 -10.22.20	Developmental Disabilities – Various Titles	Missing criteria dictated by the Final Rule and there are some areas in which the regulations conflict with requirements of the Final Rule	Appendix K

SECTION 1: ASSESSMENT OF MARYLAND'S HCBS PROGRAMS

WAIVER FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

BACKGROUND

The Autism Waiver is a collaborative effort between the MSDE (Operating State Agency) and the MDH (State Medicaid Agency), 24 local school systems, and private sector partners within Maryland with a goal to enable children with Autism Spectrum Disorder (ASD) to remain in their homes and communities. Through the waiver, Maryland children and their families receive services such as respite, therapeutic integration, and intensive individual support services provided by highly qualified professionals and trained direct care workers. The MDH provides a registry as part of an ongoing effort to address federal requirements for "state wideness" in the management and provision of the Autism Waiver and its services. Children are invited to apply for the Autism Waiver from the registry in chronological order according to the date the child was placed on the registry. Applicants are considered for the Autism Waiver by the local school systems in accordance with the waiver's medical and technical eligibility requirements. To be eligible for the Autism Waiver, a child must have an ASD diagnosis, be between the ages of one (1) and 21 (as measured by the school year in which he/she turns 21) and meet the level of care required to qualify for services in an ICF/IID. Additionally, children in the Autism Waiver must have an Individualized Education Program (IEP) and must receive at least 15 hours of special education services per week. Financial eligibility for the waiver is determined by the MDH, Eligibility Determination Division (EDD). The local school systems provide service coordination for waiver applicants and participants.

The Autism Waiver offers the following services:

1. Adult life planning (ALP)
2. Environmental accessibility adaptations
3. Family consultation
4. Intensive individual support services (IISS)
5. Respite care
6. Residential habilitation - regular and intensive levels
7. Therapeutic integration services/Intensive therapeutic integration services

The MDH renewed the Autism Waiver for a period of five (5) years on July 1, 2019.

ASSESSMENT OF SERVICE DELIVERY SYSTEM SETTINGS

From July through October 2014, the OLTSS (which was previously referred to as the Office of Health Services) and the MSDE completed a review of provider data, provider self-assessments, the 1915(c) Autism Waiver application, and applicable state regulations, the results of which are described further below.

The OLTSS and the MSDE have developed a Quality Management Strategy to review operations on an on-going basis to allow discovery of issues in provider settings, remediation of those issues, and the development and implementation of quality improvement initiatives to prevent repeat operational problems. Regular reporting and communication among the OLTSS, the MSDE, and other stakeholders, including the Waiver Advisory Council, facilitates ongoing discovery and remediation. The OLTSS is the lead entity responsible for trending data and developing and implementing system improvements based on those data. In response to the discovery of significant problem areas, the OLTSS and the MSDE may establish a specific task group or groups, which may include stakeholders such as participants, participants' families, or advocates.

The OLTSS and the MSDE monitor providers and service delivery through a variety of activities, including reviews of provider records, participant satisfaction surveys, performance measures associated with the 1915(c) Waiver, reviews of participants' plans of service, and reportable events noting alleged or actual adverse incidents that occurred with participants. These efforts will continue throughout the transition process and will be updated to include the new federal requirements for HCB settings and strategies for achieving compliance as recommended by stakeholders. The Office of Health Care Quality (OHCQ) and the DDA within the MDH license residential providers for the Autism Waiver. The MSDE reviews participants' treatment plans annually to ensure the providers ongoing compliance with licensing requirements. Parents of waiver participants and where possible, the participants themselves, meet face-to-face with their service coordinators annually. The service coordinator also engages with the participant and his/her family monthly in order to monitor service delivery, including progress on goals, determine whether services are being delivered as per the plan, and assess the participant's health status, continued eligibility, and the occurrence of any adverse incidents. As part of the MDH's transition process for HCB settings, these reviews by the service coordinators have been expanded to include assessing the new setting standards associated with the Final Rule.

In accordance with the MDH's Reportable Events Policy, all entities associated with the waiver are required to report alleged or actual adverse incidents that occurred with participants. All reportable events are analyzed by the MDH and MSDE to identify trends related to areas in need of improvement. Any person who believes that a waiver participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services as appropriate. The event report must be submitted within one (1) business day of knowledge or discovery of the incident to the MDH and the MSDE.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Provider Data

As of November 2014, eight (8) Autism Waiver services were provided by 58 community-based providers to children enrolled in the Autism Waiver. The MDH's determination regarding all service types and their degree of compliance with the Final Rule is described further in the *Preliminary Findings on Service Delivery* section below, but in short, the MDH determined that there were two (2) service types that needed to be more closely monitored to ascertain compliance with the Final Rule: intensive residential habilitation, intensive therapeutic integration, and therapeutic integration services.

Based on data from FY2016, there were five (5) providers of intensive residential habilitation and 36 participants receiving the service and 23 providers of therapeutic integration services or intensive therapeutic integration services and 476 participants receiving the service.

Reference: Appendix 1

Self-Assessment Surveys for Residential Services

From July through October of 2014, the MDH worked with The Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys to participants in settings, their representatives, and case managers. The MDH used this strategy as an initial analysis across three (3) waiver populations: the Autism Waiver, Community Pathways Waiver, and the Home and Community-Based Options Waiver (HCBOW). To support participation in the survey, participant identifying information was not collected. These surveys did not suggest that any specific program, provider, or location was non-compliant solely by classification, but rather that settings compliance would be determined through further analysis that might include additional self-assessments completed by provider settings and participants, on-site reviews, stakeholder input, and further analysis of programmatic data. Below is a brief summary of the analysis of the three (3) types of self-assessments, which is inclusive of all three (3) waivers and not specific to Autism Waiver providers and participants. The Hilltop Institute completed a full analysis and made recommendations to the MDH, which can be found in Appendix 10.

Provider Self-Assessment:

- 141 provider sites completed the survey
- Of these, 65 were assisted living provider sites and 71 were residential habilitation sites
- Five (5) sites failed to complete the survey
- The survey included several questions about the physical location of their setting, as well as the type of individuals served at the setting

Participant Self-Assessment:

- 646 participants completed the survey
- Of these, 71 indicated they lived in an assisted living unit, 186 indicated they lived in a group home/alternative living unit, 205 indicated they lived in neither an assisted living unit or a group home/alternative living unit, six (6) indicated they did not know how the setting should be categorized, and 178 did not answer the question

Case Manager Self-Assessment:

- 187 case managers completed the survey

Based on the information gathered from the preliminary surveys, several areas were identified for further review, including those provider settings that may be institutional in nature, settings that may be isolating to participants (e.g., multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates based on survey data (e.g., access to food, locking the front door, and leases/residential agreements). The survey results also indicated that the MDH should further assess an individual's control over his/her personal resources, community access and involvement, an individual's ability to file complaints, and an individual's choice of a private room or roommate.

Waiver Application and Regulations Assessments

In 2014, the MDH, along with the MSDE, completed a review of state regulations, including the Autism Waiver program regulations (COMAR 10.09.56), provider licensing requirements, waiver applications, and the State Plan to determine the level of compliance with the new federal requirements. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the Association of University Centers on Disabilities (AUCD), National Association of Councils on Developmental Disabilities (NACDD), and the National Disability Rights Network. This allowed for consistency

across programs and authorities.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule, but no areas of the regulations that conflict with the Final Rule that required remediation. See Appendix H for specific details.

PRELIMINARY FINDINGS ON SERVICE DELIVERY

Through the process described above, the MDH determined that the following waiver services comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community:

1. ALP
2. Environmental accessibility adaptations
3. Family consultation
4. IISS

Respite care is defined as offering appropriate care and supervision to protect children's safety in the absence of family members and includes assistance with activities of daily living. Respite care can be provided in a child's place of residence, a community setting, a Youth Camp certified by the MDH, or a site licensed by the DDA to accommodate individuals for respite care. Based on guidance received from the CMS, the MDH believes that because respite services are also allowable in facilities that do not meet the HCB settings criteria this service does not need further review.

By contrast, in FY2022, the MDH determined that the following waiver services need further review and remediation to fully comply with the regulatory requirements of the Final Rule. The MDH is currently working with providers that provide these services to develop remediation strategies and timelines to implement the changes needed to achieve full compliance.

1. Therapeutic integration services/Intensive therapeutic integration services
2. Residential habilitation

Therapeutic integration is available as a structured program of therapeutic activities based on a child's individualized treatment plan and focuses heavily on expressive therapies and therapeutic recreational activities as well as the development of a child's communication and social skills, enhancement of self-esteem, improved peer interaction, and behavior management. Daily sessions are a minimum of 30 minutes and a maximum of four (4) hours and services are provided at a location outside of a child's home. Intensive therapeutic integration services are provided to children whose needs require one-to-one support to allow participation in community settings with their peers. This service is for participants who are unable to participate in a regular therapeutic integration setting and require a staffing ratio of 1-1 or 2-1.

There are no licensed facilities for therapeutic integration or intensive therapeutic integration and these services are provided at a "non-residential setting separate from the home or facility where the participant lives (COMAR 10.09.56.14)." Approved therapeutic integration sites may be found in locations such as churches, schools, or separate recreation centers run specifically by the provider for the purpose of therapeutic integration and participants are integrated with other children without disabilities. As participants in the Autism Waiver are minors, these service sites are essentially after school programs for two (2) to four (4) hours.

Furthermore, current program regulations (COMAR 10.09.56.06-1) require that a provider: 1) provide documented evidence of services in the least restrictive environment in the community that is appropriate to a participant's needs; and 2) provide documented evidence of integration of the covered services with other community-based services received by participants.

Residential habilitation services are community-based residential placements for children who cannot live in their homes because they require highly supervised and supportive environments. Residential habilitation provides a therapeutic living program of treatment, intervention, training, supportive care, and oversight in which services are designed to assist children in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. These services are offered at a regular or intensive level and reimbursed at one of two rates. The intensive level of services involves awake overnight and one-on-one staffing.

ASSESSMENT STRATEGIES AND FINDINGS

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

- In 2015, the MDH created Transition Advisory Teams, which met regularly until early 2017;
- The MDH reviewed Maryland law and all regulations related to the Autism Waiver program and determined that nothing conflicted with the Final Rule; however, some areas of the Final Rule are not addressed by the regulations.

The state is still in the process of achieving compliance. The State has reported its progress with the Final Rule compliance during the monthly Maryland Medicaid Advisory Council (MMAC) meeting and various program council meetings or advisory meetings.

In August 2022, Maryland Medicaid program staff participated in the State Ombudsman advisory meeting to present information on the Final Rule. An Ombudsman is an advocate for residents of nursing homes, care homes, and assisted living facilities who addresses concerns from advocates, the participant, and the State. The State's program staff will continue to participate in the quarterly Ombudsman program stakeholders' meetings. The State will also continue to answer questions from stakeholders specific to the Final Rule through meetings, emails, phone calls, or on-site visits with providers.

Due to the PHE, the in-person stakeholder and advisory meetings were halted. The meetings will resume in FY 2023 prior to and after the transition period to communicate updates regarding the Final Rule compliance and address stakeholder's questions and concerns. The State is focused on achieving compliance and has developed a timeline that will achieve compliance with the Final Rule by March 17, 2023.

<u>Additional Provider Self-Assessment Surveys</u>

Based on the results of the initial self-assessment survey in 2014, the MDH developed and implemented a new self-assessment survey, which they piloted with providers in Fall 2015, and then administered with providers in January 2016. To ensure full response, the MDH suspended non-responsive providers until they completed the self-assessment. The MDH and The Hilltop Institute analyzed the data from the provider survey to determine the degree of compliance with all components of the Final Rule. The tool developed by The Hilltop Institute used to validate the site was a checklist referred to as *The Residential Site Visit Checklist* and providers completed this through the web-based Qualtrics data collection tool.

Corrective Action Plans

The MDH sought input from the Transition Advisory Teams on a standardized provider Corrective Action Plan (CAP) template and development of a reconsideration request process. The CAP was prepopulated with concerns for specific sites based on the provider's responses to the survey questions and the MDH's compliance coding schema. Any provider who felt that they misunderstood the survey question(s) or that the MDH misunderstood their response(s) had the opportunity to submit a request for reconsideration. Providers had up to 30 calendar days to submit their CAP to the MDH for review.

Site Visits

As part of the MDH's revalidation process for all Medicaid providers, the MDH conducts site visits to ensure compliance with the standards of the Affordable Care Act (ACA). ACA compliance site visits are not the same as, but are in addition to settings validation site visits. ACA compliance reviews did not incorporate settings criteria in their review tool; however, observations were made regarding settings criteria and issues identified were referred to the HCBS settings team for further review.

In FY 2019, the MDH visited nine (9) providers, of which had a combined total of 22 residential habilitation provider sites for the Autism Waiver. On-site and virtual visits were completed for a total of 20 sites. As of November 2022, two (2) sites are being assessed and validated with the expectation that this assessment and validation will be complete no later than December 16, 2022. As such, these two (2) sites are currently categorized as non-compliant. Based on the provider's responses to the site visit questions, a transition plan was issued with specific concerns related to non-compliance and information on how to become compliant with the Final Rule. Providers had up to 30 calendar days to submit their transition plan to the MDH for review. Twenty (20) sites submitted transition plans outlining how they were working toward Final Rule compliance. As noted below, three (3) of the 20 sites have achieved compliance with the Final Rule. The additional two (2) sites will be given 30 calendar days to submit a transition plan if they are determined to be non-compliant after the assessment and validation results.

The validation results are listed below:

Autism

Total Residential Providers: 9
Total Residential Sites: 22
Total Compliant Residential Sites: 3
Total Non-Compliant Residential Sites: 19
Total Heightened Scrutiny: 0

The remediation strategies for the non-compliant validated sites are outlined in Maryland's Remediation Strategies starting on page 52.

In October 2022, the MDH conducted virtual visits to all Autism Waiver non-residential settings to validate the results of the provider self-assessment survey and to determine compliance with the Final Rule. The MDH completed site visits for (28) Therapeutic Integration (TI) sites. Based on the provider responses to the site

visit questions a determination of compliance or non-compliance with the Final Rule was made. The MDH applied for and was approved for an Appendix K flexibility as a result of the Public Health Emergency (PHE) that temporarily waives certain criteria that are conditions of participation under the Autism Waiver.

Per the Appendix K, the Department temporarily expanded the typical setting in which Therapeutic Integration (TI) and Intensive Therapeutic Integration (ITI) could be provided. This expansion allowed these services to take place in a participant's home if a provider's site was closed using a remote service delivery model. Treatment plans must continue to reflect TI and ITI programming even when offered in the home environment. TI and ITI ratios are adjusted according to the number of children in the home setting who are approved for these services. TI and ITI must continue to be structured, therapeutic, and based on the child's need for intervention and support as outlined on the child's treatment plan.

As a result of the Appendix K flexibility, the State completed virtual site visits for those sites that remain open to determine compliance with the Final Rule. If the site was performing services remotely, the site was determined to be compliant as the service was provided in a participant's home or the broader community. Below are the results of the State's assessment and validation process:

Therapeutic Integration (TI)

Total Non-Residential (TI) Providers: 26
Total Non-Residential (TI) Sites: 26
Total Non-Residential (TI) Compliant Sites: 26
Total Non-Residential (TI) Non-Compliant Sites: 0
Total Heightened Scrutiny: 0

COMMUNITY PATHWAYS, COMMUNITY SUPPORTS AND FAMILY SUPPORTS WAIVERS

BACKGROUND

The Community Pathways, Community Supports and Family Supports 1915(c) Waivers are operated by the DDA, with oversight by the OLTSS, and provide services and supports to individuals with intellectual and developmental disabilities, living in the community, through self-directed services or DDA-certified or DDA-licensed provider agencies. Upon submission of Maryland's initial STP in 2017, the DDA only operated one 1915(c) Waiver (Community Pathways), but in 2018, Maryland implemented two (2) additional 1915(c) Waivers, Community Supports and Family Supports, to allow a larger population of individuals with developmental disabilities to access targeted services and supports. The Community Pathways Waiver provides 29 different types of services classified as meaningful day, support services, or residential services delivered by DDA-certified, DDA-licensed, or independent service providers throughout the State and also includes the option of self-direction. Under self-direction, individuals may obtain the services of a Support Broker and receive Fiscal Management Services (FMS) to assist in the planning, budgeting, management, and payment of the individual's services and supports. The Community Supports Waiver provides the same meaningful day and support services as the Community Pathways Waiver with the exception of residential services, while the Family Supports Waiver provides support services only and does not provide residential or meaningful day services. To participate in any of the 1915(c) Waivers operated by the DDA, an individual must need the level of care required to qualify for services in an ICF/IID.

The DDA's vision is for individuals to have full lives in the community of their choice where they are included and participate as active citizens. The DDA has established six (6) focus areas - self-determination, self advocacy, employment, technology, independent living, and supporting families. As an Employment First state and in line with the DDA's vision for inclusive community living, Maryland is committed to enhancing community employment options for individuals with developmental disabilities. Employment First is a concept to facilitate the full inclusion of individuals with the most significant disabilities in the workplace and broader community. Under the Employment First approach, community-based, integrated employment is the first option for employment services for youth and adults with significant disabilities. The guiding principle of Employment First is that all individuals who want to work can work and contribute to their community when given opportunity, training, and supports that builds upon their unique talents, skills, and abilities. As fully participating members of their community, individuals with developmental disabilities should be afforded the opportunity to earn a living wage and engage in work that makes sense to them. The DDA will support career exploration and planning when assisting individuals in making informed choices with respect to designing their unique pathway to increased independence, integration, inclusion, productivity, and self-determination.

The DDA is also committed to supporting the families of individuals with developmental disabilities. In 2016, Maryland joined the National Community of Practice (CoP) for Supporting Families to build its capacity to support families caring for family members with intellectual and developmental disabilities across the lifespan. Informed by the principles of Charting the LifeCourse Framework, the DDA and its Maryland CoP partners are working to create programs, policies, and practices to enhance the lives of Maryland families. Their shared goal is to support families so they can best support, nurture, love, and facilitate opportunities for their family members' achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life.

In 2018, the DDA established an Advisory Committee of stakeholders, including advocacy groups and families, to make recommendations to the DDA regarding policies and practices that favor supporting individuals with intellectual and developmental disabilities in independent housing situations where housing is separate from services. The DDA accepted the following recommendations from the Advisory Committee: (1) create a DDA Rent Subsidy Program; (2) explore and provide recommendations for the development and maintenance of a housing waitlist for individuals with intellectual and developmental disabilities; (3) clarify

roles and functions of Regional Housing Committees; and (4) specify how Maryland will create and maintain an information clearing house for people with developmental disabilities to support them in becoming productive members of their communities. Additionally, in line with the vision for individuals to live full lives, the DDA is embarking upon Maryland becoming a Technology First state. This initiative will empower individuals with intellectual and developmental disabilities to increase their independence in pursuing employment, living independently, and engaging in their communities through the use of technology.

The Community Pathways Waiver offers the following services:

1. Assistive technology and services
2. Behavioral support services
3. Career exploration
4. Community development services
5. Community living-Group home
6. Community living-Enhanced supports
7. Day habilitation
8. Employment discovery and customization
9. Employment services
10. Environmental assessment
11. Environmental modifications
12. Family and peer mentoring supports
13. Family caregiver training and empowerment services
14. Housing support services
15. Individual and family directed goods and services
16. Live-in caregiver supports
17. Medical day care
18. Nursing support services
19. Participant education, training and advocacy supports
20. Personal supports
21. Respite care services
22. Remote support services
23. Shared living
24. Support broker services
25. Supported employment
26. Supported living
27. Transition services
28. Transportation
29. Vehicle modifications

The MDH renewed the Community Pathways Waiver for a period of five (5) years on July 1, 2018.

The Community Supports Waiver offers the following services:

1. Assistive technology services
2. Behavioral support services
3. Career exploration
4. Community development services
5. Day habilitation
6. Employment discovery and customization
7. Employment services
8. Environmental assessment
9. Environmental modifications
10. Family and peer mentoring supports
11. Family caregiver training and empowerment services
12. Housing support services
13. Individual and family directed goods and services
14. Medical day care
15. Nursing support services
16. Participant education, training and advocacy supports
17. Personal supports
18. Respite care services
19. Support broker services
20. Supported employment
21. Transportation
22. Vehicle modifications

The MDH received approval for the Community Supports Waiver for a period of five (5) years on July 1, 2019.

The Family Supports Waiver offers the following services:

1. Assistive technology services
2. Behavioral support services
3. Environmental assessment
4. Environmental modifications
5. Family and peer mentoring supports
6. Family caregiver training and empowerment services
7. Housing support services
8. Individual and family directed goods and services
9. Nursing support services

10. Participant education, training and advocacy supports
11. Personal support services
12. Respite care services
13. Support broker services
14. Transportation
15. Vehicle modifications

The MDH received approval for the Family Supports Waiver for a period of five (5) years on July 1, 2019.

ASSESSMENT OF SERVICE DELIVERY SYSTEM SETTINGS

From July through October 2014, the OLTSS and the DDA completed a review of Maryland's National Core Indicator (NCI) surveys, licensed provider data, self-assessment surveys, the DDA Statute, the 1915(c) Community Pathways Waiver application, and applicable state regulations, the results of which are described further below.

The OLTSS and the DDA have developed a Quality Management Strategy to review operations of the three (3) 1915(c) Waivers on an on-going basis to allow discovery of issues, remediation of those issues, and the development and implementation of quality improvement initiatives to prevent repeat operational problems. The OLTSS and the DDA, or their designated agents, monitor the service delivery through a variety of activities, including reviews of licensure surveys, person-centered plans, reportable events noting alleged or actual adverse incidents that occurred with participants, NCI surveys, and conducting on-site visits to provider sites. These efforts will continue throughout the transition process and have been updated to include the new federal requirements for HCB settings and strategies for achieving compliance as recommended by stakeholders.

The OHCQ within the MDH is the designated licensing agent for the DDA providers. The OHCQ is authorized to issue new licenses and renew licenses for existing licensed providers and conduct inspections as part of its routine surveys or a specific investigation. The OHCQ can cite providers for non-compliance with state regulations, including Title 10, Subtitle 22, which is related to licensure and quality of care standards for the DDA providers. Based on the severity of the finding, the OHCQ may require a plan of corrections from the provider, issue sanctions, or pursue disciplinary action including license suspension or revocation.

The Coordinators of Community Services (CCS), which serve as case managers for the three (3) 1915(c) Waivers operated by the DDA, as well as the DDA regional office staff and the OHCQ review participants' person-centered plans to ensure they comply with programmatic regulations. The CCS also conducts a quarterly face-to-face visit with the participant and his/her family to monitor service delivery, including progress on goals, determine whether services are being delivered as per the plan, and assess the participant's health status, continued eligibility, and the occurrence of any adverse incidents.

In accordance with the MDH's Policy on Reportable Incidents and Investigations (PORII), all entities associated with the DDA-operated waivers are required to report alleged or actual adverse incidents that occurred with participants, including unauthorized restraints, in the DDA incident module. All reportable events are analyzed by the MDH to identify trends related to areas in need of improvement. Any person who believes that a waiver participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement, Adult or Child Protective Services as appropriate, and the applicable DDA regional office. The event report must be submitted within one (1) business day of knowledge or discovery of the incident to the DDA.

The DDA also utilizes the NCI surveys to evaluate performance related to core indicators. Core indicators are standardized measures used across states to assess the outcomes of services provided to individuals and families and include key areas such as employment, participants' rights, service planning, community inclusion, participant choice, and participant health and well-being.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Below are brief summaries of each activity in which the OLTSS and the DDA engaged as part of the initial assessment of the DDA service delivery system to determine compliance with the Final Rule. The initial assessment was general in nature and did not imply that any specific provider or location was non-compliant solely as a result of classification or service type.

NCI Surveys

The DDA has conducted the NCI Adult Family Survey, Family/Guardian Survey, and an in-person survey for the past 15 years. The NCI Adult Family Survey and Family/Guardian Survey, which can be completed electronically or via paper, is administered to a sample of individuals who are receiving services from the DDA and gathers data on approximately 60 participant outcomes. In-person surveys are conducted by interviewers who meet with individuals and ask questions about where the individuals live and work, the kinds of choices they make, the activities in which they participate in their communities, their relationships with friends and family, and their health and well-being. The core indicators from the NCI surveys can be linked to the Final Rule.

In some areas, Maryland scored above the national average and in other areas below. Based on the results from the 2020-2021 surveys:

- 61% of respondents from Maryland and 67% across NCI states reported that they choose the agency that provides services
- 47% of respondents from Maryland and 62% across NCI states reported that they choose or can change their support worker
- 81% of respondents from Maryland and 79% across NCI states reported that they participate in community activities
- 62% of respondents from Maryland and 62% across NCI states reported that they have friends other than family or paid support

Licensed Provider Data

The DDA providers may specialize in providing services to a particular group, such as individuals with a high degree of medical complexity, individuals with behavioral challenges, or individuals who are forensically involved. A DDA provider may also be licensed to provide more than one (1) waiver service. The data below provides an overview of the number of licensed provider sites, the number of sites per service type, and the number of individuals supported per site as of November 2014. While the DDA providers of services are the same across the three (3) 1915(c) Waivers, because the Community Pathways Waiver was the only waiver operated by the DDA at the time of the initial STP, the data below excludes Community Supports and Family Supports participants. These data were used to target providers and sites for further review.

Community living-Group home:

- 170 licensed providers, 2,464 provider sites

Reference: Appendix 8

Day habilitation:

- 216 sites
- The number of participants per site ranges from one (1) to 537

Based on these service types, the MDH needed to engage in a further review to assess whether any HCB settings may have institutional qualities or be isolating individuals from the broader community due to the structure of the setting, the proximity of one setting to another, or the provision of services only to individuals with disabilities with no or limited community interactions. In addition, the DDA providers shared concerns regarding community inclusion in rural areas due to inadequate transportation and limited businesses and community resources (e.g. libraries, malls, restaurants), which can hinder opportunities for individuals with developmental disabilities to seek employment and work in competitive and integrated settings, actively engage in community life, and receive services in the community to the same degree as individuals who do not receive HCBS.

Self-Assessment Surveys for Residential Services

From July through October of 2014, the MDH worked with The Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys to participants and their representatives, providers, and case managers. The MDH used this strategy as an initial analysis across three (3) waiver populations: the Autism Waiver, Community Pathways Waiver, and the HCBOW. To support participation in the survey, participant identifying information was not collected. These surveys did not suggest that any specific program, provider, or location was non-compliant solely by classification, but rather that compliance would be determined through further analysis that might include additional self-assessments by participants, on-site reviews, stakeholder input, and further analysis of programmatic data for the setting. The Hilltop Institute completed a full analysis and made recommendations to the MDH, which can be found in Appendix 10.

Based on the information gathered from the preliminary surveys, areas were identified for further review, including those settings that may be institutional in nature, settings that may be isolating to participants (e.g., multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates based on survey data (e.g., access to food, locking the front door, and leases/residential agreements). Because residential settings have various sites that are established to meet the individual needs of participants, a concern was shared that the initial self-assessment survey, which was based on a single site or facility, was not an accurate reflection as their answers may vary depending on the site for which they were responding. The survey results also indicated that the MDH should further assess an individual's control over their personal resources, community access and involvement, an individual's ability to file complaints, and an individual's choice of a private room or roommate.

DDA Statute, Waiver Application, and Regulations Assessments

In 2014, the OLTSS and the DDA completed a review of state regulations, including the Community Pathways Waiver program regulations (COMAR 10.09.26), targeted case management (TCM) regulations (COMAR 10.09.48), and general developmental disabilities services regulations (COMAR 10.22) to determine the level of compliance with the new federal requirements. Regulations and statutes pertaining to institutional settings only were not included in the review as they are not considered community settings, thus outside the scope of the Final Rule. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the AUCD, NACDD, and the National Disability Rights Network. This allowed for consistency across programs and authorities. The DDA also procured consultants to review the Community Pathways Waiver application, including service definitions, performance measures and other quality enhancement strategies, self-direction policies, and TCM. These efforts included various opportunities for stakeholder input, including public

listening sessions facilitated by the consultants. Detailed information regarding these efforts can be found here.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule and areas that conflict with the Final Rule that required remediation. See Appendix K for specific details.

PRELIMINARY FINDINGS ON SERVICE DELIVERY

Through the process described above, the MDH determined that the following waiver services comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community. While the service name and description may have changed slightly since 2014, the MDH's initial analysis and the salient characteristics of the service remain unchanged. In addition, the DDA implemented two (2) new 1915(c) Waivers since the initial STP; however, the services provided through those waivers are included alongside the MDH's initial analysis below.

1. Assistive technology and services – Technology and equipment to help participants live more independently
2. Behavioral support services – Services that assist individuals who exhibit challenging behaviors in acquiring skills, gaining social acceptance, and becoming full participants in the community. These services are provided in residential habilitation sites, participant's homes, and other non-institutional settings to help increase a participant's independence. While current regulations (COMAR 10.22.10.08 and 10.22.10.09) permit physical restraint and use of mechanical restraints and supports when the individual's behavior presents a danger to self, serious bodily harm to others, or for medical reasons, the regulations also require a formal behavioral plan with informed consent from the individual or his/her guardian, as applicable, to authorize the use of restraints.[2]
3. Career exploration – Time-limited services that assist participants in learning skills to work towards competitive integrated employment
4. Community development services – Assists an individual with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities
5. Employment discovery and customization – Community-based services provided for up to six (6) months that are designed to provide discovery, customization, and training activities to assist an individual in gaining competitive employment at an integrated job site where the individual is receiving comparable wages
6. Employment and supported employment services – A variety of flexible supports to assist participants in identifying career and employment interests and finding and keeping jobs
7. Environmental modifications – Adaptations to make an individual's environment more accessible
8. Environmental assessment – An assessment for the purpose of adaptations and modifications to an individual's environment to help him/her live more independently
9. Family and peer mentoring supports – Mentoring provided to participants and their family members by individuals with shared experiences
10. Family caregiver training and empowerment services – Education and support to the family/caregiver of a participant that seeks to preserve the family unit and increase the family/caregiver's confidence, stamina, and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the participant's person-centered plan.

[2] All staff are trained using the Mandt System, a behavioral crisis interaction training tool, to provide positive supports to individuals and de-escalation techniques to avoid the use of restraints.

11. Individual and family directed goods and services – Services, equipment, or supplies that enable the participant to maintain or increase independence and promote opportunities for the participant to live, and be included, in the community
12. Housing support services – Time-limited supports to assist participants in identifying and navigating housing opportunities, addressing or overcoming barriers to housing, and securing and retaining their own homes
13. Live-in caregiver supports – Funds the additional cost of rent and food that can be reasonably attributed to an unrelated live-in caregiver who is residing in the same household with the individual he/she is supporting
14. Nursing support services – Nursing consultation, health case management, and/or delegation services provided by a registered nurse, licensed in Maryland, which are based on the participant's assessed need
15. Participant education, training and advocacy supports – Funds for the cost associated with training programs, workshops, and conferences intended to assist a participant in developing self-advocacy skills, exercising civil rights, and acquiring skills needed to exercise control and responsibility over other support services
16. Personal supports – Individualized, drop-in supports intended to support an individual's independence in his/her own home and community with the goal of increased community integration and/or skill development or retention
17. Remote support services – Oversight and monitoring within the participant's home through an offsite electronic support system in order to reduce or replace the amount of staffing a participant needs, while ensuring the participant's health, safety, and welfare
18. Respite care services – Services provided in an individual's home and/or a community setting, which offer short-term relief when a regular caregiver is absent or needs a break
19. Support broker services – Assistance to an individual with self-directed services
20. Supported employment – Includes a variety of supports to help an individual identify career and employment interest, as well as to find and keep a job
21. Supported living – Provides participants with a variety of individualized services to support living independently in the community
22. Transition services – Funds intended to cover set-up expenses when an individual is moving from (1) an institutional setting to a group home or private residence in the community, for which the participant or their legal representative will be responsible; or (2) a community residential provider to a private residence in the community, for which the participant or their legal representative will be responsible
23. Transportation – Services designed specifically to improve an individual's ability to independently access community activities in his/her community in response to needs identified through the participant's person-centered plan
24. Vehicle modifications– Modifications to a vehicle to meet an individual's disability-related needs

Respite care, as defined above, is provided in an individual's home and/or a community setting. Based on guidance received from the CMS, the MDH believes that because respite services are also allowable in facilities such a nursing facility (NF) or assisted living facility (ALF) that do not meet the HCB settings criteria, this service does not need further review.

Supported Employment is provided in a community-integrated setting, day habilitation site, or a job site. Supported employment can include non-work activities such as job development or job placement that may take place prior to a participant becoming employed. This service can also include on-the-job training in work and work related skills. This service required further review when the service was provided in a day habilitation site. The community-integrated settings and job site meet the settings rule because the service is provided in the community. All provider owned and operated day habilitation sites are considered non-residential and were assessed and validated as noted below. This service cannot be provided at the participant's private residence or other living arrangements. When receiving the Supported Employment service, the participant is conducting contract work that meets the Competitive Integrated Employment (CIE) checklist requirements; therefore, meeting the community settings rule as the checklist ensures that an individual with a disability is receiving the same services as someone who does not

have a disability.

Facility-Based Supports are services provided at a fixed site that is owned, operated, or controlled by a licensed provider or doing work under a contract being paid by a licensed provider. Facility-Based Supports are provided within the day habilitation site to prepare the participant for the workforce. Career Exploration is a time limited service to help participants learn skills to work toward competitive integrated employment. Teaching methods based on recognized best practices such as systematic instruction are used. Career Exploration provides the participant with opportunities to develop skills to work in a competitive employment position in an integrated community environment. This may include:

1. Skills for employment, such as time-management and strategies for completing work tasks;
2. Socially acceptable behavior in a work environment;
3. Effective communication in a work environment; and
4. Self-direction and problem-solving for a work task.

Job development and job placement activities are not at a specific site. These services support a participant to obtain an individual job in a competitive integrated employment setting in the general workforce, including:

1. Customized employment - a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both.
2. Self-employment - including exploration of how a participant's interests, skills and abilities might be suited for the development of business ownership.

The MDH determined that the following waiver services need further review to determine if they fully comply with the regulatory requirements of the Final Rule. The MDH continues to work with providers that provide these services to further assess and, if needed, develop remediation strategies and timelines to implement the changes needed to achieve full compliance.

1. Community living (group home and enhanced supports)

Services are provided in a residential setting owned or operated by a licensed provider and assist individuals with activities of daily living, instrumental activities of daily living, and learning the skills necessary to be as independent as possible with their own care and community living.

2. Day habilitation

Services assist participants with the development and maintenance of skills related to activities of daily living, instrumental activities of daily living, vocation, and socialization through the application of formal teaching methods and their participation in meaningful activities.

3. Medical day care

Medical day care consists of a program of medically supervised, health-related services provided in an ambulatory setting to medically disabled adults who need health maintenance and restorative services to support their continued living in the community. Medical day care provider settings are licensed by the OHCQ and monitored by the OLTSS as part of the Medical Day Care Services Waiver. As such, these services were reviewed for licensing by OHCQ and settings compliance was reviewed by Medicaid staff to be in compliance with the Final Rule under the Medical Day Care Services Waiver.

4. Shared living

Shared living consists of an arrangement in which an individual, couple, or family in the community share(s) his/her/their home with a participant. The individual, couple, or family support(s) the participant in the same manner as he/she/they would a family member, including engaging in all aspects of community life. No more than three (3) participants requiring support may reside in an individual's, couple's, or family's home at one time. The State does not preclude foster care-type settings. Shared living is provided in privately-owned homes referred to as host homes. There is a shared living provider agency who helps coordinate and facilitate the shared living arrangement with a host home at the request of a participant. The person or family who agrees to share their home then receives a stipend from the shared living provider agency to help the person fully engage in community life. The provider agency provides oversight and monitoring of the host home. Additionally, the State is applying specific guardrails to support the participant's health and welfare which includes the person-centered planning process, case management, and the CSQ.

ASSESSMENT STRATEGIES AND FINDINGS

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

Transition Advisory Teams

The MDH established a DDA-specific Transition Advisory Team to provide information and guidance related to the STP due to the unique needs of individuals with developmental disabilities and the DDA provider network. The group included program participants, participants' family members, advocates, and representatives from various stakeholder organizations such as People on the Go (self-advocacy organization), the Maryland Developmental Disabilities Council, the Maryland Center for Developmental Disabilities, the DDA Quality Advisory Council, Disability Rights Maryland (formerly the Maryland Disability Law Center), The Arc of Maryland, the CCS Coalition, and the Maryland Association of Community Services (MACS) (provider association).

Additional Provider Self-Assessment Surveys

In partnership with the DDA Transition Advisory Team and with assistance from The Hilltop Institute, the MDH developed new provider-specific (i.e., Residential and Non-Residential) comprehensive self-assessment surveys tailored for the DDA service delivery system to provide additional data related to compliance with the Final Rule. As noted in The Hilltop Institute's analysis of the initial survey results, there were several limitations to the initial self-assessment surveys as they did not account for different waiver populations or service delivery systems. Prior to the implementation of the new provider self-assessment surveys, the MDH piloted the surveys with a group of residential and non-residential provider volunteers to test the survey questions and results. The surveys were then revised based on recommendations from the DDA Transition Advisory Team and disseminated to the applicable provider groups.

Non-Residential Provider Self-Assessments

The MDH emailed the DDA non-residential provider settings in April of 2016 to notify them of the need to complete the forthcoming provider self-assessment, provided the assessment instrument to preview, and shared information regarding webinars intended to assist them in completing the self-assessment. The MDH also sent providers a personalized follow-up email in advance of the webinars, which were held at the end of April 2016. During the webinars, the MDH instructed

the providers to complete a self-assessment by mid-May 2016 for each service they provided and inclusive of each site they operated. While the MDH gave settings a May deadline, the survey remained open until July 2016.

One hundred seventeen (117) providers completed self-assessments, resulting in 377 completed assessments. Day habilitation accounted for 48 percent of the completed assessments. The Hilltop Institute released a report in September 2016 titled "HCBS Final Rule: DDA Non-Residential Provider Self-Assessment Summary."

Residential Provider Self-Assessments

The MDH emailed the DDA residential providers in June of 2016 to notify them of the need to complete the forthcoming provider self-assessment, provided the assessment instrument to preview, and shared information regarding webinars intended to assist them in completing the self-assessments. The MDH also sent providers a personalized follow-up email in advance of the webinars, which were held mid-June 2016. During the webinars, the MDH instructed providers with 40 or fewer sites to complete assessments for all of their sites by the end of July 2016 and providers with more than 40 sites were instructed to complete assessments for all of their sites by the end of August 2016. While the MDH gave providers the requisite deadlines, the survey remained open until November 2016.

One hundred thirty-four (134) providers completed self-assessments, resulting in 1,964 completed assessments. The maximum number of assessments completed by a provider was 75, while the minimum was one (1). The average number of assessments completed by a provider was 15. ALU providers accounted for 64 percent of the completed assessments. The Hilltop Institute released a report in November 2016 titled "HCBS Final Rule: DDA Residential Provider Self-Assessment Summary". There is no longer a shareable link for the report released by The Hilltop Institute due to the security incident that occurred in December 2021. The State no longer has access to many of the links previously shared; however, a copy of the report is available upon request of the MDH.

In 2016, the self-assessment tool was completed for a statistically significant sample. As noted, 1,964 residential and 377 non-residential settings completed the survey. Providers that did not complete the self-assessment tool were assessed using the CSQ and validated by a desk audit of the CSQ, person-centered plan, reportable events, on-site visits, and reviews of licensure survey findings.

The revised self-assessment tool includes all HCBS settings criteria. All new settings are required to complete the assessment for their prospective sites. In 2019, each new setting was required to comply with provider enrollment settings requirements prior to becoming a Medicaid-enrolled approved setting eligible to provide waiver services. The self-assessment tool was used in programs as an indicator of presumptive new provider settings compliance. Settings compliance is currently validated by site visit or CSQ.

All residential sites indicated above will not receive on-site visits; however, by July 2022, each residential site was validated by the use of the CSQ. As noted in the STP, data from the CSQ was compared to the participant self-assessment surveys and the provider self-assessment surveys administered in 2014 and 2016 respectively to validate the results of those surveys. As indicated, all non-residential settings were assessed and validated by on-site visit.

Validation of Provider Self-Assessments for both Non-Residential and Residential Settings

The DDA requested that The Hilltop Institute explore multiple strategies to validate the results of the provider self-assessment surveys, including geomapping, CSQs, citation tags from the OHCQ and employment data. When multiple validation strategies existed for a single question, the most appropriate one was chosen based on the data. In order to determine provider compliance, the MDH linked specific requirements of the Final Rule to particular questions in line with the

compliance coding schema. Based on the coding schema, provider non-compliance on any one (1) indicator for a specific requirement was deemed non-compliant with the regulation. Additionally, the MDH designated key questions within the self-assessments as "red flag" questions.

The CSQ for residential settings lists the individual's current residential information and is linked to the LTSS*Maryland*, Maryland's software program supporting case management and service delivery for several Medicaid Home and Community-Based Service programs. There is a CSQ for both residential and non-residential settings. Although there are two versions of the CSQ for residential and non-residential sites for DDA provider settings, all participants complete the residential CSQ, and those participants receiving services in a non-residential setting also complete the non-residential CSQ. All CSQ data is housed in LTSS*Maryland*. The non-residential CSQ is linked to the data collection tools, such as provider settings' trackers located within the prospective programs. The validation process included the use of the CSQ that was implemented with the start of Community First Choice (CFC) in January of 2014. This questionnaire has been vetted with CMS to ensure the participants of the 1915(k) were residing in settings that followed the HCB settings rule. This questionnaire, which is completed annually and at the time of a residence change by the Supports Planner with the participant's participation. The use of the CSQ was expanded to include participants in the 1915(c) Waiver Programs to ensure participants were residing in settings that followed the HCB settings rule.

MDH currently monitors providers and service delivery through a variety of other activities including: quality reviews, Money Follows the Person Quality surveys, data analysis, plan of service reviews, Reportable Events, and communication with participants and providers. Participants' plans of service, prepared by Supports Planners, are reviewed by plan of service reviewers at the MDH, and the Office of Health Care Quality (OHCQ) does face-to-face visits to ensure ongoing compliance with the licensing requirements in residential settings. Participants in residential and non-residential settings meet with their case managers quarterly for virtual and face-to-face meetings to monitor service delivery, including progress on goals, assessment of services as per the plan, status and confirmation of health services, eligibility, and reportable incidents. These plans are submitted to MDH at least annually or as needed for review.

Provider Transition Plans

The MDH sought input from the DDA Transition Advisory Team on a standardized Provider Transition Plan template, guidance regarding completion of the transition plan, and development of a reconsideration request process. The Provider Transition Plan was prepopulated with concerns for specific sites based on the provider's responses to the survey questions and the MDH's compliance coding scheme. Any provider who felt that they misunderstood the question(s) or that the MDH misunderstood their response(s) had the opportunity to submit a request for reconsideration. Providers had up to 90 calendar days to submit their Provider Transition Plan to the MDH for review.

Participant Assessments

As part of the plan to achieve compliance with the Final Rule, the DDA began using the CSQ approved by the CMS in conjunction with the 1915(k) State Plan program, Community First Choice (CFC), for all waiver participants. The initial effort to collect data through the CSQ was completed in 2017; since then, the CSQ is administered by the CCS at least annually or with any change in settings. Data from the CSQ was compared to the participant self-assessment surveys and the provider self-assessment surveys administered in 2014 and 2016 respectively to validate the results of those surveys.

Site Visits

As part of the MDH's revalidation process for all Medicaid providers, the MDH conducts site visits to ensure compliance with the standards of the ACA. During the site visit, the surveyor takes photos of the facility to document whether it is open and operational and scans for accessibility, and settings criteria such as

multiple sites in one location, farmsteads, and other potential isolating characteristics. The surveyor also notes any observed unsafe conditions and/or inappropriately locked (or unlocked) spaces. The surveyors then share this information with specific MDH programs for further assessment. This information is reviewed in tandem with settings criteria to ensure compliance with the Final Rule reviewed by Medicaid staff.
Based on the MDH's analyses, which includes the provider self-assessment surveys in 2016 for residential and non-residential settings, the MDH identified specific sites that needed further review, including additional site-specific assessments and on-site visits. The DDA subsequently coordinated and completed site visits for 100 percent of non-residential settings providers between July and December of 2017. For residential setting, the DDA utilized the CSQ to assess the setting and validated the results via a desk audit of the CSQ, person-centered plan, reportable events, on-site visits, and reviews of licensure survey findings.

The outcome of the non-residential site visit results are as follows:

Total Non-Residential Providers: 105
Total Non-Residential Sites: 213
Total Compliant Non-Residential Sites: 213
Total Non-Compliant Non-Residential Sites: 0
Total Heightened Scrutiny Sites: 0

The outcome of residential settings' results are as follows:

Total Residential Providers: 153
Total Residential Sites: 2,469
Total Compliant Residential Sites: 2,469
Total Non-Compliant Residential Sites: 0
Total Heightened Scrutiny Sites: 0

COMMUNITY PERSONAL ASSISTANCE SERVICES AND COMMUNITY FIRST CHOICE

BACKGROUND

The MDH operated the Medical Assistance Personal Care (MAPC) program, which provided personal assistance services to older adults and individuals with physical disabilities, through the State Plan until 2013. In 2014, MAPC transitioned to the Community Personal Assistance Services (CPAS) program, which remained part of the State Plan under the 1915(j) authority. Individuals of any age are eligible to participate in the CPAS program, but they must meet the required level of care and qualify for Medicaid in the community.

The MDH also implemented the CFC program in 2014 as part of the State Plan under the 1915(k) authority. Individuals of any age are eligible to participate in the CFC program, but they must meet an institutional level of care and qualify for Medicaid in the community.

The CPAS program offers the following services:

1. Personal assistance services
2. Case management (referred to as supports planning)
3. Nurse monitoring

The CFC program offers the following services:

1. Personal assistance services
2. Case management (referred to as supports planning)
3. Nurse monitoring
4. Personal emergency response systems
5. Assistive technology
6. Environmental assessments
7. Environmental adaptations
8. Consumer training
9. Transition services
10. Home-delivered meals

PRELIMINARY FINDINGS ON SERVICE DELIVERY

The MDH determined that all services and supports provided through the CPAS and CFC programs comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community. Additionally, the programs were in compliance with the Final Rule since their implementation in 2014 and compliance has been assessed continuously since that time through the administration of the CSQ, at least annually, with each participant.

HOME AND COMMUNITY-BASED OPTIONS WAIVER

BACKGROUND

The HCBOW is operated by the OLTSS and provides services and supports to older adults and individuals with physical disabilities, which allows them to reside in their homes and communities as an alternative to an institutional setting. Participants must be at least 18 years of age and meet the level of care required to qualify for NF services.

The HCBOW offers the following services:

1. Assisted living
2. Behavior consultation
3. Case management
4. Family training
5. Dietician and nutritionist services
6. Medical day care
7. Senior Center Plus
8. Respite care

The MDH is currently renewing the HCBOW for a period of five (5) years.

ASSESSMENT OF SERVICE DELIVERY SYSTEM SETTINGS

The OLTSS has developed a Quality Management Strategy to review operations of the HCBOW on an on-going basis to allow discovery of issues, remediation of those issues, and the development and implementation of quality improvement initiatives to prevent repeat operational problems. The OLTSS, or their designated agents, monitor provider settings and service delivery through a variety of activities, including reviews of provider data, plans of service, reportable events noting alleged or actual adverse incidents that occurred with participants, and conducting on-site visits to sites. These efforts will continue throughout the transition process and have been updated to include the new federal requirements for HCB settings and strategies for achieving compliance as recommended by stakeholders. More specifically, the OLTSS is engaged in the following activities to monitor providers and service delivery:

- The OLTSS engages a variety of stakeholders, including participants, participants' families, advocates, and providers through the Community Options Advisory Council, which meets every other month to provide a participatory venue for sharing program updates and eliciting feedback.
- The CSQ, which was implemented with the CFC program and has been compliant with the Final Rule from its inception in January 2014, is completed with all waiver participants. The CSQ was approved by the CMS for use as a participant survey.
- The case managers (hereafter referred to as supports planners) for HCBOW participants review plans of service at least quarterly to monitor service delivery, including progress on goals, determine whether services are being delivered as per the plan, and assess the participant's health status, continued

eligibility, and the occurrence of any adverse incidents. A supports planner must submit the CSQ prior to submitting a participant's plan of service to the OLTSS for review.

- The OLTSS provides orientation for Medicaid provider applicants seeking to provide assisted living services under the HCBOW. All assisted living facilities (ALF) must attend an orientation session prior to being enrolled as an Medicaid provider. This process is in addition to the 80-hour course that ALF managers must take before the facility will be considered for licensure. ALF providers receive information about the Final Rule and the CSQ during orientation.

In accordance with the MDH's Reportable Events Policy, all entities associated with the waiver are required to report alleged or actual adverse incidents that occurred with participants. All reportable events are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that a waiver participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services as appropriate. The event report must be submitted within one (1) business day of knowledge or discovery of the incident to the OLTSS.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Provider Data

The MDH's determination regarding all service types and their degree of compliance with the Final Rule is described further in the *Preliminary Findings on Service Delivery* section below, but in short, the MDH determined that there were three (3) service types that needed to be more closely monitored to ascertain compliance with the Final Rule: medical day care, Senior Center Plus, and assisted living.

Based on claims data from FY2014, there were 117 medical day care sites and 4,781 HCBOW participants receiving this service under the HCBOW, seven (7) Senior Center Plus sites and 30 HCBOW participants receiving this service, and 452 ALF sites and 1,509 HCBOW participants receiving this service.

Self-Assessment Surveys for Residential Services

From July through October of 2014, the MDH worked with The Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys to participants and their representatives, providers, and case managers. The MDH used this strategy as an initial analysis across three (3) waiver populations: the Autism Waiver, Community Pathways Waiver, and the HCBOW. To support participation in the survey, participant identifying information was not collected. These surveys did not suggest that any specific program, provider, or location was non-compliant solely by classification, but rather that compliance would be determined through further analysis that might include additional self-assessments by providers and participants, on-site reviews, stakeholder input, and further analysis of programmatic data. Below is a brief summary of the analysis of the three (3) types of self-assessments, which is inclusive of all three (3) waivers and not specific to HCBOW settings and participants. The Hilltop Institute completed a full analysis and made recommendations to the MDH, which can be found in Appendix 10.

Provider Self-Assessment:

- 141 providers completed the survey
- Of these, 65 were assisted living providers and 71 were residential habilitation providers

- Five (5) providers failed to complete the survey
- The survey included several questions about the physical location of their setting, as well as the type of individuals served at the setting

Participant Self-Assessment:
- 646 participants completed the survey
- Of these, 71 indicated they lived in an assisted living unit, 186 indicated they lived in a group home/alternative living unit, 205 indicated they lived in neither an assisted living unit or a group home/alternative living unit, six (6) indicated they did not know how the setting should be categorized, and 178 did not answer the question

Case Manager Self-Assessment:
- 187 case managers completed the survey

Based on the information gathered from the preliminary surveys, several areas were identified for further review, including those settings that may be institutional in nature, settings that may be isolating to participants (e.g., multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates based on survey data (e.g., access to food, locking the front door, and leases/residential agreements). The survey results also indicated that the MDH should further assess an individual's control over his/her personal resources, community access and involvement, an individual's ability to file complaints, and an individual's choice of a private room or roommate.

Waiver Application and Regulations Assessments

In 2014, the MDH completed a review of state regulations, including the HCBOW program regulations (COMAR 10.09.54) and ALF regulations (COMAR 10.07.14), and the HCBOW application to determine the level of compliance with the new federal requirements. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the AUCD, NACDD, and the National Disability Rights Network. This allowed for consistency across programs and authorities.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule and, specific to COMAR 10.07.14, areas that were in conflict with the Final Rule that required remediation. See Appendix B and Appendix G for specific details.

PRELIMINARY FINDINGS ON SERVICE DELIVERY

Through the process described above, the MDH determined that the following waiver services comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community:

1. Behavior consultation
2. Case management
3. Family training
4. Dietician and nutritionist services

Additionally, respite care under the HCBOW may be provided in an individual's home and/or a community setting, as well as in an ALF or NF. Based on guidance received from the CMS, the MDH believes that because respite services are also allowable in facilities that do not meet the HCB settings criteria this service does not need further review.

By contrast, the MDH determined that the following waiver services need further review and remediation to fully comply with the regulatory requirements of the Final Rule. The MDH will work with providers of these services to develop remediation strategies and timelines to implement the changes needed to achieve full compliance.

1. Medical day care

Medical day care consists of a program of medically supervised, health-related services provided in an ambulatory setting to medically disabled adults who need health maintenance and restorative services to support their continued living in the community. Medical day care providers are licensed by the OHCQ and monitored by the OLTSS as part of the Medical Day Care Services Waiver. As such, these services were reviewed for compliance with the Final Rule under the Medical Day Care Services Waiver.

2. Senior Center Plus

Senior Center Plus is a program of structured group activities and enhanced socialization provided for four (4) or more hours a day, which is designed to facilitate an individual's optimal functioning, orientation, and cognitive ability. Senior Center Plus is provided in an outpatient setting, most often within a senior center, and as the program does not include health-related services it is considered an intermediate option between senior centers and medical day care. The specific services available in a Senior Center Plus program include social and recreational activities designed for older adults and individuals with disabilities, assistance with activities of daily living and instrumental activities of daily living, and one (1) meal.

3. Assisted living

A licensed facility that provides housing and supportive services for individuals who need assistance in performing activities of daily living and instrumental activities of daily living. The MDH noted that ALF provider sites used a variety of leases or residency agreements, which required further review to determine if the leases and residency agreements in use were indeed legally enforceable.

ASSESSMENT STRATEGIES AND FINDINGS

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

- In 2015, the MDH created Transition Advisory Teams, which met regularly through early 2017.
- The MDH reviewed Maryland law and all regulations related to the HCBOW and determined that with reference to COMAR 10.07.14, there were areas that conflicted with the Final Rule that required remediation.

- Through the person-centered planning process, the OLTSS ensures that participants are provided the opportunity to make an informed choice regarding their residence and are supported in relocating if desired or necessary. HCBOW participants are required to sign a Freedom of Choice (FOC) form prior to enrollment attesting to the choice of residence in the community (as opposed to an institution setting) and choice of providers from those who are available.

Additional Provider Self-Assessment Surveys

Based on the results of the initial self-assessment survey in 2014, the MDH developed and implemented a new self-assessment survey, which they piloted with providers in the Fall of 2015, and then administered with settings in January 2016. To ensure full response, the MDH suspended non-responsive providers until they completed the self-assessment. The MDH and The Hilltop Institute analyzed the data from the provider survey to determine the degree of compliance with all components of the Final Rule. The following data are specific to ALF settings in the HCBOW:

- Twenty-nine (29) settings identified themselves as being located in a NF, institution for mental diseases (IMD), ICF/IID, or hospital. As such, these settings were likely subject to the MDH's heightened scrutiny review as part of the site visits discussed below unless the OLTSS determined the self-report was inaccurate.
- Thirty-nine (39) provider settings identified themselves as being located on the grounds of, or adjacent to, a facility that provides inpatient institutional treatment. The OLTSS posited that many of those 39 providers were duplicative of the aforementioned 29 providers who indicated they were located in a NF, IMD, ICF/IID, or hospital as the survey questions were similar.
- Twenty-one (21) providers reported complete compliance with all requirements of the Final Rule, meaning none of the content covered by the 75 questions on the survey were of concern.

The questions on the survey most frequently responding in a negative response were:

Survey Questions	Total Number of Negative Responses
Do participants have keys to their entrance door (i.e., the front door)?	381
Do participants control their own funds (i.e., participants have their own checking or savings account that they manage)?	368
Do participants have keys to their bedroom doors?	350

Corrective Action Plans

The MDH sought input from the Transition Advisory Teams on a standardized provider CAP template and development of a reconsideration request process. The CAP was prepopulated with concerns for specific sites based on the provider's responses to the survey questions and the MDH's compliance coding schema. Any provider who felt that they misunderstood the survey question(s) or that the MDH misunderstood their response(s) had the opportunity to submit a request for reconsideration. Providers had up to 30 calendar days to submit their CAP to the MDH for review.

Participant Assessments

As part of the plan to achieve compliance with the Final Rule, the OLTSS implemented the CSQ approved by the CMS in conjunction with the CFC program for the HCBOW and collected CSQ data for all participants by mid-May 2016. The CSQ is administered by the Supports Planner at least annually or with any change in service settings and all CSQ data for HCBOW participants is stored in LTSS*Maryland*. Data from the CSQ was compared to the participant self-assessment surveys and the provider self-assessment surveys administered in 2014 and 2016 respectively to validate the results of those surveys.

Site Visits

As of April 2016, there were 668 ALF providing services to HCBOW participants. Beginning in May 2016, as part of the revalidation process for all Medicaid providers settings, the MDH began conducting site visits to all ALF settings to ensure compliance with standards of the ACA. During the site visits, the surveyors review information required under the ACA, including the three (3) questions below, which pertain to community settings:

- Is the site located in, adjacent to, or on the grounds of a NF, IMD, ICF/IID, or hospital?
- Is the site near other private residences or retail businesses and not physically isolated from the greater community (i.e., not a gated setting, secured community, farm community, or campus setting)?
- Is all personal information about participants kept in a secure and private location (e.g., in a locked file cabinet)?

The surveyors also note any observed unsafe conditions and/or inappropriately locked (or unlocked) spaces. The surveyors then share this information with specific MDH programs for further assessment.

In July 2017, the OLTSS began conducting additional site visits with residential service provider settings, which for the HCBOW consists solely of ALF, including those settings that had been determined to meet the criteria for heightened scrutiny. In FY2020, the first and second round of visits were successfully completed. Forty-five percent (45%) of active assisted living facilities were determined to be 100 percent compliant as of October 2, 2020. During FY2021, the OLTSS implemented virtual site visits for new and existing ALF sites. In the spring of FY2021, the OLTSS began conducting a third round of site visits (virtual) for the 55 percent of settings that had not been determined to be compliant as a result of the first and second round of visits.

In June 2021, the OLTSS completed its review of a third round of on-site and virtual site visits for settings that had not yet been determined to be compliant as a result of the first and second round visits. The results of those visits are as follows:

Assisted Living
Total Assisted Living Facilities: 547
Total Compliant Sites: 294
Total Non-Compliant Sites: 253 (1 of 253 presumed Heightened Scrutiny)
Heightened Scrutiny: 1

The remediation strategies for the non-compliant validated sites are outlined in Maryland's Remediation Strategies starting on page 52.

INCREASED COMMUNITY SERVICES

BACKGROUND

Maryland's Increased Community Services (ICS) program allows individuals who are overscale for income for the HCBOW to receive the services and supports offered through the HCBOW and contribute a monthly assessment fee towards the costs of services. The ICS program is supported by an 1115 demonstration waiver, administered directly by Maryland Medicaid.

The ICS program offers the following services, which align with those offered through the HCBOW:

1. Assisted living
2. Behavior consultation
3. Case management
4. Family training
5. Dietician and nutritionist services
6. Medical day care
7. Senior Center Plus
8. Respite care

As the ICS program offers the same services as the HCBOW, the MDH's determination can be found under *Preliminary Findings on Service Delivery* in the HCBOW analysis.

MEDICAL DAY CARE SERVICES WAIVER

BACKGROUND

The Medical Day Care Services Waiver is operated by the OLTSS and offers services to qualified participants in a community-based day care facility. Medical day care centers operate five (5) to seven (7) days a week and must provide a minimum of four (4) hours of services per day to participants. Participants must be at least 16 years of age and meet the level of care required to qualify for NF services.

Medical day care includes the following services:

1. Prevention, diagnosis, treatment, rehabilitation and continuity of care assessments
2. Skilled nursing and nursing assessments, including medication monitoring
3. Physical therapy
4. Occupational therapy
5. Personal care (i.e., assistance with activities of daily living and instrumental activities of daily living)
6. Nutrition services, including meals
7. Social work services, including daily living skills training and enhancement
8. Activity programs
9. Transportation (to and from the medical day care center)

The MDH is currently renewing the Medical Day Care Services Waiver for a period of five (5) years.

ASSESSMENT OF SERVICE DELIVERY SYSTEM SETTINGS

The OLTSS has developed a Quality Management Strategy to review operations of the Medical Day Care Services Waiver on an on-going basis to allow discovery of issues, remediation of those issues, and the development and implementation of quality improvement initiatives to prevent repeat operational problems. The OLTSS, or their designated agents, monitor providers and service delivery through a variety of activities, including reviews of provider data, care plans, reportable events noting alleged or actual adverse incidents that occurred with participants, and conducting on-site visits. These efforts will continue throughout the transition process and have been updated to include the new federal requirements for HCB settings and strategies for achieving compliance as recommended by stakeholders. More specifically, the OLTSS is engaged in the following activities to monitor provider settings and service delivery:

- The OLTSS in engaged in frequent communication with the OHCQ, which licenses medical day care centers, including collaborating to remediate issues that are negatively impacting participant health and well-being
- The OLTSS engages medical day care providers through the Advisory Council to share program updates and elicit feedback
- The OLTSS reviews each participant's care plan at least annually to determine whether services are being delivered as per the care plan and assess the participant's health status, continued eligibility, and the occurrence of any adverse incidents.

In accordance with the MDH's Reportable Events Policy, all entities associated with the waiver are required to report alleged or actual adverse incidents that occurred with participants. All reportable events are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that a waiver participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services as appropriate. The event report must be submitted within one (1) business day of knowledge or discovery of the incident to the OLTSS.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Provider Data

Based on claims data from FY2016, there were 119 medical day care sites and 5,632 participants receiving the medical day care service, which is inclusive of those receiving the service through all 1915(c) Waivers.

Reference: Appendix 4

Waiver Application and Regulations Assessments

In 2014, the MDH completed a review of state regulations, including the Medical Day Care Services Waiver program regulations (COMAR 10.09.61 and 10.09.07), the OHCQ's regulations for medical day care centers (COMAR 10.12.04), and the Medical Day Care Services Waiver application to determine the level of compliance with the new federal requirements. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the AUCD, NACDD, and the National Disability Rights Network. This allowed for consistency across programs and authorities.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule, but no areas that conflict with the Final Rule that required remediation. See Appendix C and Appendix J for specific details.

ASSESSMENT STRATEGIES AND FINDINGS

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

- In 2015, the MDH created Transition Advisory Teams, which met regularly through early 2017.
- The MDH reviewed Maryland law and all regulations related to the Medical Day Care Services Waiver and determined that nothing conflicted with the Final Rule; however, some areas of the Final Rule were not addressed by the regulations.
- Through the person-centered planning process, the OLTSS ensures that participants are provided the opportunity to make an informed choice regarding a setting. Medical Day Care Services Waiver participants are required to sign an FOC form prior to enrollment attesting to the choice of residence in the community (as opposed to an institution setting) and choice of setting from those who are available.

Provider Self-Assessment Surveys

The MDH piloted a self-assessment survey with provider settings in Fall 2015, and then administered the survey in January 2016. To ensure full response, the MDH suspended non-responsive provider settings until they completed the self-assessment. The MDH and The Hilltop Institute analyzed the data from the provider survey to determine the degree of compliance with all components of the Final Rule. The following data are specific to medical day care sites:

- Seven (7) providers identified as being located in a NF, IMD, ICF/IID, or hospital. As such, these provider settings were likely subject to the MDH's heightened scrutiny review as part of the site visits discussed below unless the OLTSS determined the self-report was inaccurate.
- Twelve (12) providers identified themselves as being located on the grounds of, or adjacent to, a facility that provides inpatient institutional treatment. The OLTSS posited that many of those 12 provider settings were duplicative of the aforementioned seven (7) provider settings who indicated they were located in a NF, IMD, ICF/IID, or hospital as the survey questions were similar.
- Eleven (11) providers reported complete compliance with all requirements of the Final Rule, meaning none of the content covered by the 75 questions on the survey were of concern.

Corrective Action Plans

The MDH sought input from the Transition Advisory Teams on a standardized provider CAP template and development of a reconsideration request process. The CAP was prepopulated with concerns for specific sites based on the provider's responses to the survey questions and the MDH's compliance coding schema. Any provider who felt that they misunderstood the survey question(s) or that the MDH misunderstood their response(s) had the opportunity to submit a request for reconsideration. Providers were given up to 30 calendar days to submit their CAP to the MDH for review.

Conflict-Free Case Management

The Medical Day Care Services Waiver does not offer case management by an independent entity. Licensed registered nurses and licensed social workers, employed by medical day care sites, develop and implement participants' care plans, which are reviewed and approved by the OLTSS. These clinicians must comply with Maryland's Nurse and Social Work Practice Acts, which hold them accountable for individual judgments and actions and ensure clinicians act in the best interest of the participant.

Site Visits

As part of the MDH's revalidation process for all Medicaid providers, the MDH conducts site visits to ensure compliance with the standards of the ACA. In addition to these visits, the OLTSS began conducting on-site visits to medical day care sites in July 2017 to validate the results of the provider self-assessment survey and determine compliance with the Final Rule. ACA compliance is not the same as, but is in addition to site visits to validate settings compliance with the Final Rule. ACA compliance reviews did not incorporate settings criteria in their review tool. However, observations were made regarding settings criteria and issues identified were referred to the HCB settings team for further review.

As of September 2020, the MDH had conducted an on-site visit to all medical day care centers that were active at that time (109) to ensure compliance with the Final Rule. Based on the MDH's analyses of those 109 providers, 84 were compliant, 11 were issued a CAP for non-compliance, and 14 were considered a setting requiring a heightened scrutiny review.

As of June 2022, the MDH conducted additional on-site visits to the senior center plus sites and medical day care centers. The aggregate results of the additional visits and those visits completed in 2020 are as follows:

Senior Center Plus
Total Sites: 5
Total Compliant Sites: 3
Total Non-Compliant Sites: 2
Total Heightened Scrutiny: 0

Medical Day Care
Total Medical Day Care Sites: 112
Total Compliant Sites: 100
Total Non-Compliant Sites: 12 (1 of 12 presumed Heightened Scrutiny)
Total Heightened Scrutiny: 1

The remediation strategies for the non-compliant validated sites are outlined in Maryland's Remediation Strategies starting on page 52.

MODEL WAIVER FOR MEDICALLY FRAGILE CHILDREN

BACKGROUND

The Model Waiver is operated by the OLTSS and provides services to children with complex medical needs to allow them to remain in their homes instead of receiving services in an institutional setting. Participants must be enrolled in the Model Waiver prior to age 22, but may remain in the waiver as long as they meet the eligibility requirements. To be medically eligible for the Model Waiver, a participant must have complex medical needs equivalent to the level of care required to qualify for NF or chronic hospital services and be at risk of long-term hospitalization.

The Model Waiver offers the following services:

1. Case management
2. Medical day care
3. Home health aide assistance
4. Physician participation in the plan of care development
5. Private duty nursing

The MDH renewed the Model Waiver for a period of five (5) years on July 1, 2018.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Waiver Application and Regulations Assessments

In 2014, the MDH completed a review of state regulations, including the Model Waiver program regulations (COMAR 10.09.27), and the Model Waiver application to determine the level of compliance with the new federal requirements. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the AUCD, NACDD, and the National Disability Rights Network. This allowed for consistency across programs and authorities.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule, but no areas that conflict with the Final Rule that required remediation. See Appendix E for specific details.

PRELIMINARY FINDINGS ON SERVICE DELIVERY

Through the process described above, the MDH determined that the following waiver services comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community:

1. Case management

2. Home health aide assistance
3. Physician participation in the plan of care development
4. Private duty nursing

Although the MDH had determined that the service of medical day care needed further review and remediation to fully comply with the regulatory requirements of the Final Rule, there are no Model Waiver participants currently receiving these services. As such, the MDH determined that all services under the Model Waiver are currently compliant with the Final Rule and will review participant and service delivery data on a consistent basis to ensure continued compliance.

WAIVER FOR INDIVIDUALS WITH BRAIN INJURY

BACKGROUND

The Brain Injury Waiver is a collaborative effort between the Behavioral Health Administration (BHA), within the MDH, and the OLTSS and provides community-based services and supports to individuals who are referred from state-owned and operated facilities, including state psychiatric hospitals, and chronic hospitals that are accredited for brain injury rehabilitation. Participants must be between the ages of 22 and 64, be diagnosed with a brain injury (BI) which occurred after the age of 17, and need the level of care required to qualify for NF or chronic hospital services.

The Brain Injury Waiver offers the following services:

1. Day habilitation
2. Individual support services
3. Residential habilitation
4. Supported employment
5. Medical day care

The MDH renewed the Brain Injury Waiver for a period of five (5) years on July 1, 2021.

ASSESSMENT OF SERVICE DELIVERY SYSTEM SETTINGS

The OLTSS and the BHA have developed a Quality Management Strategy to review operations of the Brain Injury Waiver on an on-going basis to allow discovery of issues, remediation of those issues, and the development and implementation of quality improvement initiatives to prevent repeat operational problems. The OLTSS, the BHA, or their designated agents, monitor providers and service delivery through a variety of activities, including reviews of provider data, plans of service, reportable events noting alleged or actual adverse incidents that occurred with participants, and conducting on-site visits. With the exception of case management providers, all Brain Injury Waiver providers are licensed by the OHCQ. As part of the DDA network, DDA reviews provider enrollment applications for Brain Injury providers to allow for Medicaid enrollment. These efforts will continue throughout the transition process and have been updated to include the new federal requirements for HCB settings and strategies for achieving compliance as recommended by stakeholders.

In accordance with the MDH's Reportable Events Policy, all entities associated with the waiver are required to report alleged or actual adverse incidents that occurred with participants. All reportable events are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that a waiver participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services as appropriate. The event report must be submitted within one (1) business day of knowledge or discovery of the incident to the MDH.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Provider Data

The MDH's determination regarding all service types and their degree of compliance with the Final Rule is described further in the *Preliminary Findings on Service Delivery* section below, but in short, the MDH determined that there were four (4) service types that needed to be more closely monitored to ascertain compliance with the Final Rule: residential habilitation, day habilitation, supported employment, and medical day care. As of November 2014, 75 participants were receiving residential habilitation (58 - level 2; 17 - level 3), 62 participants were receiving day habilitation (1 - level 1; 55 - level 2; 6 - level 3), six (6) participants were receiving supported employment, and no participants were receiving medical day care services.

Waiver Application and Regulations Assessments

In 2014, the MDH completed a review of state regulations, including the Brain Injury Waiver program regulations (COMAR 10.09.46), and the Brain Injury Waiver application to determine the level of compliance with the new federal requirements. In order to crosswalk all the authorities, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings" developed by the AUCD, NACDD, and the National Disability Rights Network. This allowed for consistency across programs and authorities.

The preliminary review resulted in the identification of missing criteria dictated by the Final Rule, but no areas that conflict with the Final Rule that required remediation. See Appendix F for specific details.

PRELIMINARY FINDINGS ON SERVICE DELIVERY

Through the process described above, the MDH determined that the following waiver service complies with the regulatory requirements of the Final Rule because it is an individualized service provided in a participant's private home or the community:

1. Individual support services

By contrast, the MDH determined that the following waiver services need further review and remediation to fully comply with the regulatory requirements of the Final Rule. The MDH will work with the provider settings that provide these services to develop remediation strategies and timelines to implement the changes needed to achieve full compliance.

1. Day habilitation

This service assists participants with acquisition, retention, or improvement of self-help, socialization, and/or adaptive skills, and takes place in a non-residential, facility-based setting, separate from the participant's residence. These services must be provided a minimum of four (4) hours per day.

2. Residential habilitation

This service is provided in a residential setting and assists participants with acquisition, retention, or improvement of skills related to activities of daily living and the social and adaptive skills necessary to enable the participant to live in a non-institutional setting. The MDH must grant an exception for any individual living in a home with greater than three (3) individuals. In reviewing these exceptions requests, the MDH considers the following: 1) the wishes of the individuals living in or proposing to live in the home, 2) the interests of the individuals living in or proposing to live in the home, and 3) the health and well-being of individuals living in or proposing to live in the home.

Based on the MDH's review of current provider data, there are several residential sites that the State is assessing to ensure compliance with the Final Rule. The MDH also noted that residential settings used a variety of leases or residency agreements, which required further review to determine if the leases and residency agreements in use were indeed legally enforceable. In line with this concern, stakeholders suggested the adoption of a standardized lease or agreement.

3. Medical day care

Medical day care consists of a program of medically supervised, health-related services provided in an ambulatory setting to medically disabled adults who need health maintenance and restorative services to support their continued living in the community. Currently, there are no Brain Injury Waiver participants receiving this service, but the MDH will review participant and service delivery data on a consistent basis to ensure continued compliance.

4. Supported employment

Supported employment is individual employment support, including transportation assistance from the participant's residence to place of employment, for participants who, because of their disabilities, need intensive on-going support to obtain and maintain competitive, customized or self- employment in an integrated work setting at or above the state's minimum wage in a job that meets personal and career goals. Supported employment may be provided in a variety of settings including a community-integrated setting, day habilitation site, or a job site. Supported employment can include non-work activities including job development or job placement that may take place prior to a participant becoming employed. The community-integrated settings and job site meet the settings rule because the service is provided in the community. The majority of the time this service is provided in the community; however, when provided in a day habilitation site, the sites were assessed and validated. The eight (8) day habilitation/non-residential provider settings were assessed and validated by the DDA, whereas, the 13 residential settings were assessed and validated by the OLTSS, by virtual site visit in June 2022.

ASSESSMENT STRATEGIES AND FINDINGS

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

- In 2015, the MDH created Transition Advisory Teams, which met regularly through 2017.
- The MDH reviewed Maryland law and all regulations related to the Brain Injury Waiver and determined that nothing conflicted with the Final Rule; however, some areas of the Final Rule were not addressed by the regulations.

Provider Self-Assessment Surveys

The MDH utilized the non-residential and residential provider self-assessment surveys administered to the DDA provider setting for the Brain Injury Waiver. The non-residential provider self-assessment was administered in April of 2016 and the residential provider self-assessment was administered in June of that year. The MDH and The Hilltop Institute analyzed the data from the provider survey to determine the degree of compliance with all components of the Final Rule. The tool developed by Hilltop Institute used to validate the site was a checklist referred to as *The Residential Site Visit Checklist* and providers completed this through the web-based Qualtrics data collection tool.

Provider Transition Plans

As previously noted, with the exception of case management providers, all Brain Injury Waiver providers are also part of the DDA provider network. The Brain Injury (BI) provider sites are enrolled as a Medicaid provider by the DDA and licensed by OHCQ. They are not considered the same type of provider setting; however, they are included in the DDA assessment and validation results for non-residential and residential settings noted earlier in this document. The MDH sought input from the DDA Transition Advisory Team on a standardized Provider Transition Plan template, guidance regarding completion of the transition plan, and development of a reconsideration request process. The Provider Transition Plan was prepopulated with concerns for specific sites based on the provider's responses to the survey questions and the MDH's compliance coding scheme. Any provider who felt that they misunderstood the question(s) or that the MDH misunderstood their response(s) had the opportunity to submit a request for reconsideration. Providers were given up to 90 calendar days to submit their Provider Transition Plan to the MDH for review.

Site Visits

As part of the MDH's revalidation process for all Medicaid providers, the MDH conducts site visits to ensure compliance with the standards of the ACA. During the site visit, the surveyor takes photos of the facility to document whether it is open and operational and scans for accessibility and settings criteria such as multiple sites in one location and other potential isolating characteristics. The surveyor also notes any observed unsafe conditions and/or inappropriately locked (or unlocked) spaces. The surveyors then share this information with specific MDH programs for further assessment.

Based on the MDH's analyses, which includes the provider self-assessment surveys in 2016, the MDH identified specific sites that needed further review, including additional site-specific assessments and on-site visits. The DDA conducted 100% on-site visits for non-residential provider settings between July and December of 2017. The 13 Brain Injury sites were assessed and validated by the OLTSS staff by way of a virtual visit in May 2022. The eight (8) non-residential Brain injury sites were included in the on-site visits completed by the DDA, as such, the validation results are incorporated in the results for all DDA providers noted on page 30 and disaggregated from the DDA results below. This will allow for distinction between the DDA operated programs (Community Pathways Waiver, Community Supports Waiver and Family Supports Waiver) and the Brain Injury Waiver.

The finalized assessment and validation results for these provider settings are listed below:

Total Non-Residential Providers: 8
Total Non-Residential Sites: 8
Total Compliant Non-Residential Sites: 8
Total Non-Compliant Non-Residential Sites: 0
Total Heightened Scrutiny: 0

Total Residential Providers: 2
Total Residential Sites: 13
Total Compliant Residential Sites: 0
Total Non-Compliant Residential Sites: 13
Total Heightened Scrutiny: 0

Education and remediation strategies will continue to ensure the provider sites are compliant with the Final Rule. The remediation strategies for the non-compliant validated sites are outlined in Maryland's Remediation Strategies starting on page 52.

INTENSIVE BEHAVIORAL HEALTH SERVICES FOR CHILDREN, YOUTH AND FAMILIES

BACKGROUND

The 1915(i) State Plan program is administered by the MDH and provides community-based treatment to children and youth with serious emotional disturbance (SED) and their families through a wraparound service delivery model. Each participant's child and family team develops an individualized plan of care, which is implemented in partnership with a Care Coordination Organization (CCO) through the TCM program. Participants must enroll before the age of 18 and may receive services through age 21.

Previously, Maryland operated a special demonstration project known as the Residential Treatment Center (RTC) Waiver. This time-limited demonstration project used a special authority granted by the CMS under Section 1915(c) of the Social Security Act to provide home and community-based services for children and youth with SED and their families. In order to sustain and refine the approach undertaken in the initial demonstration, the MDH created a 1915(i) State Plan Amendment (SPA) to serve a similar, but not identical, population of youth and families.

The State Plan program offers the following services:

1. Customized goods and services
2. Expressive and experiential therapy
3. Family peer support services
4. Mobile crisis response services
5. Intensive in-home services
6. Respite services

PRELIMINARY FINDINGS ON SERVICE DELIVERY

The MDH determined that the following 1915(i) services comply with the regulatory requirements of the Final Rule because they are individualized services provided in a participant's private home or the community:

1. Customized goods and services - Participant-directed expenditures that support a participant's plan of care, selected in partnership with the CCO
2. Expressive and experiential therapy - Therapeutic modalities that include art, dance, music, equine, horticulture, or drama to accomplish individualized goals as part of the plan of care
3. Family peer support services - Assisting and empowering participants' families with respect to the participants' services
4. Mobile crisis response services - Short-term, individualized services that assist in de-escalating crises and stabilizing participants in their homes and community settings
5. Intensive in-home services - Strength-based interventions that include a series of components with participants and their families

Respite services may be provided in or outside of the participant's home or in another community setting. Based on guidance received from the CMS, the MDH believes that because respite services are also allowable in facilities that do not meet the HCB settings criteria this service does not need further review.

SECTION 2: MARYLAND'S REMEDIATION STRATEGY, TIMELINE AND TRANSITION PLAN

As part of achieving compliance with Final Rule, Maryland must develop a plan to remediate, through various means, any areas of non-compliance with respect to HCB setting requirements. As the single state Medicaid agency, the MDH has developed the following remediation strategies, which include a description of the associated action(s), the timeline(s) in which those actions will be completed, the milestone to be achieved in association with those actions, and the group(s) responsible for the implementation and ongoing monitoring of the identified strategies. Some strategies may require legislative changes, budgetary actions, and/or amendments to the federal authorities underpinning Maryland's Medicaid Waivers and State Plan programs.

REGULATORY REVIEW

The Maryland General Assembly meets annually from January through April and considers any legislative and budgetary actions at that time. Additional information about the Maryland General Assembly can be found here.

Bills

The State Constitution mandates that legislative bills be limited to one subject clearly described by the title of the bill and drafted in the style and form of the *Annotated Code* (Const., Art. III, sec. 29). The one-subject limitation and the title requirement are safeguards against fraudulent legislation and allow legislators and constituents to monitor a bill's progress more easily. Ideas for bills (proposed laws) come from many sources: constituents, the Governor, government agencies, legislative committees, study commissions, special interest groups, lobbyists, and professional associations; however, each bill must be sponsored by a legislator. At the request of legislators, bills are drafted to meet constitutional standards by the Department of Legislative Services until July (the MDH receives drafting requests beginning in mid-April, shortly after the legislative session ends). In the interim between sessions, legislators meet in committees, task forces, and other groups to study and formulate bill proposals.

Budget Bill

In Maryland, the State Constitution provides for an annual budget bill. Each year, the Governor presents a bill to the General Assembly containing the budget for the state government for the next fiscal year. In Maryland, the fiscal year begins July 1st and ends June 30th. The General Assembly may reduce the Governor's budget proposals, but it may not increase them; however, whether the budget is supplemented or amended, it must be balanced; total estimated revenues must always be equal to or exceed total appropriations (Const., Art. III, sec. 52 (5a)). If the General Assembly has not acted upon the budget bill seven (7) days before the expiration of a regular legislative session, the Governor, by proclamation, may extend the session for action to be taken on the bill. After both houses pass the budget bill, it becomes law without further action (Const., Art. III, sec. 52). The Governor may not veto the budget bill.

Maryland's Regulation Process

Maryland has specific requirements for the adoption of regulation, including utilizing an emergency or standard process. The length of time to complete these processes varies depending on the time for development and stakeholder input, submission date, and public comments. At a minimum, the process takes 94 days after initial developments and submission from the state agency. The full text of each proposed regulation must be published in the Maryland Register**.** The process

includes the following: Attorney General's Review, Administrative, Executive, and Legislative Review (AELR) Committee preliminary review, Maryland Register review and publication, 30-day review and comment period, and regulations promulgation.

Amendments to Federal Authorities and Regulation Changes

Amendments or changes to Medicaid Waivers or State Plan programs require stakeholder input and public notices prior to submission to the CMS. Once submitted, the CMS has up to 90 days to review the request and may request additional information or ask questions, which can affect the timeframe.

Since submission of Maryland's initial STP, the MDH moved forward with the proposed revisions to COMAR 10.09.36.03-1 to remediate the areas of conflict with and address all required criteria associated with the Final Rule as described earlier in the STP. The revised regulations were promulgated in 2018 and all Medicaid providers of HCBS must achieve and maintain compliance with those regulations.

TIMELINES AND DESCRIPTION OF THE TRANSITION PLAN

Maryland's intent with respect to the STP and remediation strategies is not to suspend or terminate providers, but instead to work with participants, providers, and other stakeholders to achieve full compliance with the Final Rule. Additionally, the State intends to ensure individuals receiving HCBS are fully integrated into the community, afforded choice, and that their health and well-being is assured. The completion of on-site visits, virtual site visits, or review of the CSQs yielded the following results for non-residential and residential HCBS settings:

- **Compliant**: In full compliance with the Final Rule and does not need any modification.
- **Non-compliant in need of remediation**: Not fully compliant but can become compliant with completion of a Corrective Action Plan (CAP) or a Transition Plan.
- **Heightened Scrutiny**: Remediation plans for providers will be developed based on the presumptive heightened scrutiny review.

The table in Appendix P outlines the strategies and timeline that Maryland has developed to assess compliance with the Final Rule and address non-compliant sites. As noted in the table, the State will send notification to providers with non-compliant sites outlining the process to submit a corrective action plan (CAP), which should indicate the steps the provider will take to come into compliance with the Final Rule. The MDH will work collaboratively with non-compliant providers who submit CAPs by providing technical assistance. Technical assistance is provided at the request of the non-compliant provider and can include on-site visits by Medicaid HCB settings staff to assist with actions such as obtaining signed residential and lease agreements and educating staff at each provider site on requirements to come into compliance with the Final Rule.

The CAP or transition plan from the provider must include remediation strategies for the non-compliant area(s) to describe what, how, and when the provider's site will become compliant with that specific settings requirement. The State will guide the provider on how to become compliant with the required regulations found in 42 CFR 441.710(a)(1)(2). Additionally, providers will be educated on how to appropriately enumerate the requirements of 42 CFR 441.301(c)(4)(vi)(F) in the person-centered plan of service for the individual. Providers will receive a timeline for ensuring compliance as outlined below. While numerous sites have completed remediation and or transition efforts, as of November 30, 2022, there are 299 non-compliant provider sites across all programs that the State will continue to monitor using the following timeline:

- October 31, 2022: MDH sent all non-compliant and complaint providers a detailed letter indicating their compliance status with the Final Rule, and the source of that determination. If the site was determined to be non-compliant with the Final Rule, the letter listed the specific areas of non-compliance and requested a CAP or transition plan to be completed and sent back to the State within 30 days from the date of the letter.
- October 31, 2022: All heightened scrutiny reviews were completed. The list containing sites determined to have the characteristics of heightened scrutiny was posted for a 30-day public comment period that ended on October 28, 2022.
- November 30, 2022: Review corrective action plans or transition plans for non-compliant sites to update compliance status by determining if the issues have been remediated. Technical assistance will be available to all providers.
- December 31, 2022: Sites that are not in compliance with the Final Rule will be suspended. MDH notifies the provider of its suspended status until compliance with the Final Rule is achieved. MDH also notifies the individual, individual's representative, and case management agency of the provider's suspended status. This allows time before the provider is disenrolled from the Medicaid program if there are still remediation actions the provider can take to come into full compliance. During this period, the Department will provide proper support to assist the individual in locating another compliant setting and ensure that the individual's rights are safeguarded.
- February 1, 2023: All participants have been notified and transitioned into a site that is in compliance with the Final Rule.
- March 1, 2023: All participants originally in settings non-compliant with the Final Rule have been prepared and given assistance to move to another setting that fully complies with the Final Rule.

The State has developed a detailed strategy for assisting participants receiving services from providers not willing or able to come into compliance with the Final Rule by the end of the transition period. The State will begin notifying individuals receiving Medicaid funded services residing in a non-compliant HCB site of the need to transition to a compliant HCB site in December 2022 with the expected completion date of December 31, 2022. In addition to notifying individuals or their representatives, the State will provide appropriate notice to case management entities and providers.

Once an individual and/or representative receives a transition notice, a person-centered plan of service will be revised by the case management agency, as part of the person-centered planning process, and will include the individual's chosen community of support. The transition process will ensure that the individual, their family, and appropriate individuals chosen through the person-centered planning process, are given proper information, the opportunity to make an informed decision, and the support to make an informed choice of an alternate HCB site. The individual will be able to choose a site that aligns with the HCB settings requirements. The site will meet the individual's assessed needs and ensure critical services and supports are in place in advance of the individual's transition date.

As the state completes the process of assessing provider sites and determines appropriate remediation plans, it has estimated the number of individuals that may need to be transitioned to other sites. As of December 1, 2022, the total number of individuals who may be impacted and need to transition is 446 participants; however, MDH will consistently provide technical assistance to providers throughout the remediation period ending on December 31, 2022. As such, the number of participants will change as additional provider sites become compliant, as participants move between sites, or as participants disenroll from a program.

REVERSE INTEGRATION

The State will ensure that residential and non-residential settings comply with all requirements of the Final rule, including integration of HCBS participants into the broader community. States cannot comply with the rule simply by bringing individuals without disabilities from the community into a HCB site. Reverse integration, or a model of intentionally inviting individuals not receiving HCBS into a facility-based site to participate in activities with HCBS participants, is not considered by itself to be a sufficient strategy for complying with the community integration criteria outlined in regulation according to CMS.

Maryland will support individuals in receiving services in the community with the same degree of access as individuals who are not receiving Medicaid HCBS. Under the Final Rule, sites must provide opportunities for community integration. Community experiences include activities that are conducted and provided in community settings. Such integration will be provided in desegregated non-disability-specific sites and can include activities such as shopping, attending church, attending sporting events, accessing employment opportunities, and participating in clubs. Community experiences should include activities and support to accomplish individual goals outlined in the person-centered plan of service (POS). Each activity can be adapted according to the individual's needs. Additionally, the site must make the individual aware of community activities and ensure the individual is able to participate in activities outside of the site. While participating in the activity, the individual will be able to interact with individuals who do not receive assistance from Medicaid in sites such as, a Senior Center Plus, a Medical Day Center, or a Day Habilitation Center. Individuals will also have the same access to transportation as other community members. In order to assess and validate a site's compliance with the community integration component of the Final Rule, Maryland is collecting items such as activities schedules, brochures and reviewing the provider's website to understand how the site is integrating the participants into the broader community. Additionally as noted previously, the CSQ, community settings visit checklist, and interviews with staff and participants during on-site or virtual visits are used to assess compliance with community integration.

Furthermore, the implementation of the Employment First initiative represents MDH's vision for inclusive community living, Maryland is committed to enhancing community employment options for individuals with developmental disabilities. Employment First is a concept to facilitate the full inclusion of individuals with the most significant disabilities in the workplace and broader community. Under the Employment First approach, community-based, integrated employment is the first option for employment services for youth and adults with significant disabilities. The guiding principle of Employment First is that all individuals who want to work can work and contribute to their community when given the opportunity, training, and support that builds upon their unique talents, skills, and abilities. As fully participating members of their community, individuals with developmental disabilities should be afforded the opportunity to earn a living wage and engage in work that makes sense to them.

SITE SPECIFIC REMEDIATION

The State will ensure that participants have access to services in non-disability specific settings among their service options for both residential and non-residential settings. The State is taking steps to build capacity among its providers to increase access to non-disability specific setting options across HCBS programs. The State will continue to ensure individuals will be supported in their choosing of provider owned and operated residences. Individuals will receive services and have the opportunity to explore integrated living options that match their identified service and support needs and choices. In order to build provider capacity, the State is:

- Assessing each program's provider data and reviewing each program's relevant service definitions, policies, and procedures within its waiver application and State regulations;
- Evaluating rate sufficiency and increasing the rate for specific services as funding sources are identified and allocated for home and community-based services;
- Exploring rebalancing initiatives through the Money Follows the Person demonstration to enhance home and community-based services and build provider capacity; and
- Initializing provider enrollment and revalidation initiatives to ensure individuals will be supported appropriately in the community as well as identify areas of concern.

As Maryland is working to build provider capacity, new providers must meet the settings criteria prior to becoming an enrolled Medicaid provider. For existing providers, the STP has described the assessment and validation strategies Maryland used to assess provider compliance with the Final Rule. The site-specific

assessment and validation for individual and privately-owned homes will be monitored for full compliance with settings criteria by reviewing the CSQ, desk audits, and on-site or virtual visits. The CSQ serves as a participant survey and will address areas of non-compliance with the Final Rule. The State will utilize a coordinated approach engaging a participant's case manager, care coordinator, or supports planner as necessary when determining a site's ongoing compliance status. All sites will be assessed and validated for HCB settings compliance criteria using the aforementioned strategies every three (3) to five (5) years.

HEIGHTENED SCRUTINY

The State has identified sites that are presumed to have qualities meeting the heightened scrutiny criteria. These are sites for which the State must submit information for the heightened scrutiny review to CMS if it determines, through its assessments, these settings have qualities that are institutional in nature and isolate individuals from the broader community. Provider self-assessments and on-site visits were used to help identify sites for a heightened scrutiny review. The MDH identified sites that appear to have institutional qualities or appear to be isolating individuals from the community. The MDH's heightened scrutiny review included, but was not limited to:

- A review of person-centered service plan and CSQ for individuals receiving services in the setting;
- Interviews with participants receiving services in the setting;
- A review of data pertaining to services utilized by participants receiving services in the specified setting;
- An on-site visit and assessment of the physical location and the settings' practices;
- A review of policies and other applicable service-related documents; and
- A review of the provider's proposed transition plan, including how the setting will implement the remediation or corrective action plan.

The State will continuously work with all sites meeting the criteria for heightened scrutiny to submit evidence to demonstrate how the providers are in compliance with the Final Rule. After sites have been identified for heightened scrutiny and evidence has been received from the provider, the State will complete an evidentiary packet for each identified site. As described in the timeline offered by the State, sites presumed for heightened scrutiny and expected to overcome the presumption will be submitted to CMS by December 16, 2022 for a final review. The heightened scrutiny list was posted for a 30-day public comment period from September 29, 2022 through October 28, 2022. The State has included the public comments and the State's responses in Appendix O in the STP.

PARTICIPANT TRANSITION TO COMPLIANT PROVIDER SITES

As noted above, Maryland's remediation strategies will include leveraging the person-centered planning process to develop a transition plan which will detail how each program will support its participants in selecting and transitioning to a new site if their current site does not comply with the Final Rule by the deadline. Timelines have been established delineating how and when participants and their case managers will receive notification from the MDH regarding the need to select and transition to a new site. The State will begin notifying individuals receiving Medicaid funded services residing in non-compliant HCBS provider sites of the need to transition to a compliant HCB setting in December 2022.

In addition to notifying individuals of the need to transition, the State will provide appropriate notice to case management entities and providers. Once an individual and/or representative receives a transition notice, a plan of service will be revised by the case management agency, as part of the person-centered planning process, involving the individual's chosen community of support. The transition process will ensure that the individual, their family, and appropriate individuals chosen through the person-centered planning process, are given proper information, the opportunity to make an informed decision, and the support to

make an informed choice of an alternate HCB site. The individual will be able to choose a site that aligns with the Final Rule requirements. The site will meet the individual's assessed needs and ensure critical services and supports are in place in advance of the individual's transition by February 1, 2023. Ongoing monitoring will verify that all HCB sites continue to meet all of the requirements under 42 CFR 441.301(c)(4)(vi)(F) and 42 CFR 441.710(a)(1)(2). A variety of review strategies will be used to monitor ongoing compliance with the Final Rule including but not limited to on-site or virtual visits, desk reviews, and review of the CSQs. Participants in HCBS programs addressed in the STP have the CSQ updated annually.

ONGOING MONITORING OF SITES

Maryland's ongoing monitoring process to ensure continued Final Rule compliance of its HCB settings will include data collection strategies used across various entities in the Waiver system including contact with participants, providers, case management entities, and other stakeholders. This data will be used to monitor quality of services and supports provided to Waiver participants as well as compliance with the Final Rule. The State will ensure that ongoing monitoring occurs for all residential and non-residential sites for compliance with the settings criteria.

The CSQ applies to both residential and nonresidential settings. It is reviewed by program staff as an assessment and/or validation strategy to determine if the site is in compliance with the Final Rule. As described in the STP, Maryland will continue to engage stakeholders with respect to the proposed remediation strategies and provide additional training and technical assistance to providers to ensure all providers have the tools and support necessary to achieve full compliance by March 17, 2023, and remain in compliance thereafter.

Reviews will verify that settings continue to meet all of the settings criteria under 42 CFR 441.301(c)(4)(i)-(vi) and 42 CFR 441.710(a)(1)(2). The State will ensure ongoing compliance by using a coordinated approach that includes entities that provide case management, care coordination, and supports planning. Additionally, MDH and the operating state agencies will assist in gathering compliance information that will be reviewed and may result in virtual visits, phone interviews, desk reviews, and on-site compliance reviews in response to any complaints or concerns. The State will assess and validate one hundred percent of HCB provider sites every three (3) to five (5) years via a variation of CSQs reviews, desk audits, and virtual or on-site visits.

All correspondence sent to providers will contain contact information for the State's HCBS settings compliance unit. Additionally providers, participants, and other stakeholders may reach the HCBS settings compliance unit using the dedicated email address, dhmh.hcbssetting@maryland.gov, that is visible on the State's website dedicated to the HCBS Settings. Case managers, Supports Planners, and Care Coordinators share any HCBS settings compliance concerns through the Reportable Events process. Participants also have the option of filing reportable events on their own behalf.

SECTION 3: PUBLIC INPUT AND COMMENT

Maryland is committed to sharing information and seeking public input into its assessment for compliance with the Final Rule and the development and implementation of the STP. In October 2014, the OLTSS (formerly the OHS) and the DDA established dedicated pages within the MDH's website related to the Final Rule. Since much progress has been made since the initially posted content, the OLTSS and the DDA are in the process of reviewing their dedicated sites and updating content to demonstrate the MDH's progress towards full implementation of the Final Rule.

During October 2014, Maryland conducted regional public information and education meetings and a webinar to share general information about the Final Rule and its assessment strategies. Approximately 400 individuals attended, including program participants, participants' family members, case managers, service providers, and various advocacy organizations. The presentation was shared at both 3:00 p.m. and 7:00 p.m. to accommodate various schedules. Maryland conducted another set of regional public information meetings and a webinar in January 2015. The purpose of these meetings was to gain input from stakeholders regarding the draft STP and proposed remediation strategies. Approximately 400 individuals attended the second public meeting as well and the presentation times and formats were similar to the October 2014 meetings. The October 2014 and January 2015 presentations, public comments, and responses were posted on the OLTSS page linked above.

Maryland posted a draft of the STP transition plan to the MDH website on December 21, 2014, with a comment period lasting through February 15, 2015. Maryland received approximately 20 sets of comments and questions from stakeholders including participants, their family members, self-advocates, advocacy organizations, legal entities, and provider networks. A summary of all comments, with responses, can be viewed here. The MDH gave careful attention to those comments that pertain specifically to the STP itself. The initial STP was submitted to the CMS in March 2015. In September 2016, Maryland posted the updated STP to the MDH's website, with a comment period initially lasting through October 2016, but later extended through February 2017. Maryland received approximately 70 sets of comments and questions from stakeholders. A summary of all comments, with responses, can be viewed here.

Maryland posted a draft of the final STP to the MDH website on March 25, 2022 with a comment period lasting through April 23, 2022. Maryland received comments and questions from three (3) stakeholders. A summary of all comments with responses, can be viewed here. Additionally, Maryland posted a list of provider sites that met the heightened scrutiny criteria based on MDH's assessment and validation results. The list was posted to the MDH website on September 29, 2022 with a comment period lasting through October 28, 2022. Maryland received six (6) comments from six (6) stakeholders. A summary of the comments and responses can be viewed here. Maryland posted a list of 28 therapeutic integration (TI) sites that were assessed and validated for settings compliance to the MDH website on January 27, 2023 with a comment period lasting through February 2, 2023. Maryland did not receive any comments during the public comment period. In addition to eliciting public feedback on the STP, the MDH conducted various program-specific stakeholder meetings between 2014 and 2017:

Date	Meeting
October 7, 2014	Balancing Incentive Plan/Money Follows the Person (BIP/MFP)
October 20, 2014	Autism Service Coordinators
October 21, 2014	Medical Day Care Waiver Advisory Council Meeting
October 23, 2014	Maryland Medicaid Advisory Committee (MMAC)
October 24, 2014	Local Health Departments Presentation

October 29, 2014	Autism Provider Focus Group
November 5, 2014	People on the Go (self-advocacy group)
November 10, 2014	The ARC of Howard County - People Power
December 6, 2014	People on the Go Statewide Meeting
February 4, 2015	Maryland Works
September 19, 2016	Medicaid HCBS Final Rule Stakeholder Meeting
January 26, 2017	DDA Transition Advisory Team Meeting: STP Public Input and Comment
February 28, 2017	St. Peter's Presentation: Community Settings Rule
April 7, 2017	Medicaid HCBS Final Rule Stakeholder Meeting: STP Public Comment
April 12, 2017	DDA Transition Advisory Team Meeting: Validation Strategies
May 3, 2017	Medicaid HCBS Stakeholder Meeting: Provider Education Manual
June 28, 2017	Medicaid HCBS Stakeholder Meeting: CMS Feedback

Additional outreach from the MDH included:

Date	Meeting
May 27, 2015	Transition Advisory Team Meeting
June 1, 2015	DDA Transition Advisory Team Meeting
June 23, 2015	DDA Transition Advisory Team Meeting
June 24, 2015	Transition Advisory Team Meeting
August 21, 2015	Transition Advisory Team Meeting: The Hilltop Institute
August 25, 2015	HCBS Stakeholder Meeting
September 14, 2015	DDA Transition Advisory Team Meeting
September 25, 2015	Transition Advisory Team Meeting
October 20, 2015	DDA Transition Advisory Team Meeting
December 17, 2015	DDA Transition Advisory Team Meeting
December 18, 2015	Transition Advisory Team Meeting
January 11, 2016	HCBS Transition Advisory Team Meeting
January 25, 2016	DDA Transition Advisory Team Meeting
February 3, 2016	Eastern Shore DDA Public Outreach Meeting
February 16, 2016	Central Region DDA Public Outreach Meeting

February 29, 2016	Western Maryland DDA Public Outreach Meeting
March 2, 2016	Southern Maryland DDA Public Outreach Meeting (Town Hall)
March 3, 2016	DDA Transition Advisory Team Meeting
March 4, 2016	HCBS Stakeholder Meeting
April 8, 2016	DDA Transition Advisory Team Meeting
April 12, 2016	HCBS Stakeholder Meeting
June 2, 2016	DDA Transition Advisory Team Meeting
June 9, 2016	HCBS Stakeholder Meeting
September 12, 2016	Southern Region DDA Public Outreach Meeting
September 12, 2016	DDA Statewide Discussion Session: Self-Direction, State Transition
September 19, 2016	Western Region DDA Public Outreach Meeting
September 19, 2016	DDA Statewide Discussion Session: Self-Direction, State Transition
September 26, 2016	Central Region DDA Public Outreach Meeting
September 26, 2016	DDA Statewide Discussion Session: Self-Direction, State Transition
September 27, 2016	DDA Stakeholder Meeting: HCBS Final Rule
October 3, 2016	Eastern Shore DDA Public Outreach Meeting
October 3, 2016	DDA Statewide Discussion Session: Self-Direction, State Transition
November 16, 2016	DDA Transition Advisory Team Meeting: Provider Transition Plan
February 13, 2017	DDA Transition Advisory Team Meeting
February 28, 2017	DDA Transition Advisory Team Meeting

Provider meetings included:

Date	Meeting
November 6, 2014	Maryland Association of Community Services (MACS) Workgroup
November 12, 2014	MACS Annual Conference Closing Plenary
June 21, 2016	Medical Day Care Provider Meeting
July 1, 2016	Medical Day Care Provider Meeting
August 2, 2016	Residential Habilitation and Therapeutic Integration Providers for Autism Waiver Meeting (Webinar and In-Person)
August 16, 2016	DDA "Tiered Standards" Meeting

September 20, 2016	Medical Day Care Waiver Advisory Council Meeting
December 21, 2016	MACS Presentation: Provider Transition Plan (PTP)
February 28, 2017	MDC Waiver Advisory Council Meeting

SUMMARY OF STATEWIDE TRANSITION PLAN CHANGES

A high-level summary of the changes from Maryland's initial STP submitted and approved by CMS on August 2, 2017 and the current STP include:

- Updates to the total number of provider sites for the waiver programs due to new enrollment and disenrollment of provider sites;
- Updates to the Maryland Transition Remediation Strategy table were made to reflect changes in Maryland's remediation strategies and timeline for completion for sites to achieve full compliance with the final rule. Additionally, the table was removed from the body of the STP and placed in Appendix P;
- The final STP includes the Family Supports Waiver and the Community Supports Waiver created in 2018;
- The revised self-assessment tool includes all HCBS settings criteria. All new sites are required to complete the assessment for their prospective sites. In 2019, each new site was required to comply with provider enrollment requirements prior to enlisting in the Medicaid Waiver as an approved site. The self-assessment tool was used in programs as an indicator of presumptive new provider settings compliance. Settings compliance is currently validated by site visit or CSQ;
- In 2016, the self-assessment tool was completed for a statistically significant sample. As noted, 1,964 residential and 377 non-residential settings completed the survey. After the approval of the initial STP, providers that did not complete the self-assessment tool were assessed using the CSQ and validated by a desk audit of the CSQ, person-centered plan, reportable events, on-site visits and reviews of licensure survey findings; and
- The State assessed all new providers who enrolled after the initial provider lists were identified in 2014. Settings criteria was added to the provider enrollment process and each new site that applied to become a Medicaid provider was evaluated and required to comply with provider enrollment settings requirements prior to enlisting in the Medicaid program as an approved setting.

In closing, it is Maryland's intention to assist each participant with understanding the full benefit of the HCB settings requirements and to assist each provider in achieving and maintaining full compliance with the Final Rule. Maryland will continue to engage stakeholders with respect to the proposed remediation strategies and provide additional training and technical assistance to providers, as necessary, to ensure all providers have the tools and support necessary to achieve full compliance by March 17,2023 and remain in compliance thereafter.

SECTION 4: APPENDICES

Appendix A - Residential Services Agencies

Appendix B - Assisted Living Programs

Appendix C - Medical Day Care

Appendix D - Community Pathways Waiver Program for Individuals with Developmental Disabilities

Appendix E - Home Care for Disabled Children Under a Model Waiver

Appendix F - Home and Community-Based Services Waiver for Individuals with Brain Injury

Appendix G - Home and Community-Based Options Waiver

Appendix H - Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder

Appendix I - Home and Community-Based Options Waiver, Intensive Behavior Services for Children, Youth, and Families

Appendix J - Medical Day Care Facilities

Appendix K - DDA Regulations

Appendix L - Public Comments 2015

Appendix M - Public Comments 2016

Appendix N - Public Comments March 2022

Appendix O - Public Comments Heightened Scrutiny October 2022

Appendix P - Maryland Remediation Strategies

Appendix 1 - Autism Waiver Recipients and Providers

Appendix 2 - Home and Community-Based Options Waiver Recipients and Providers FY16

Appendix 3 - Community Pathway Waiver Recipients and Providers FY16

Appendix 4 - Medical Day Care Recipients and Providers

Appendix 5 - Model Waiver for Medically Fragile Children Recipients and Providers FY 16

Appendix 6 - Traumatic Brain Injury Recipients and Providers by Waiver Service FY16

Appendix 7 - DDA Shared Living

Appendix 8 - Residential Provider Summary

Appendix 9 - DDA Day and Supported Employment

Appendix 10 - Hilltop HCBS Final Rule Provider Self-Assessment Summary 2016

Appendix 11 - Medicaid and DDA Mail Merge Letters

Appendix 12 and 13 - Community Settings Questionnaires (CSQs) 2017

Appendix 14 - OHS Crosswalk