



ADVANCING OPTIMAL COMMUNITY INCLUSION & MAXIMUM
QUALITY IN HOME AND COMMUNITY-BASED SERVICE PROVISION:

MAINE'S FINAL STATEWIDE TRANSITION PLAN
FOR IMPLEMENTING THE FEDERAL HOME &
COMMUNITY-BASED SERVICES RULE

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Maine Department of Health and Human Services
Office of MaineCare Services
Office of Aging and Disability Services

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Foreword

In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued new federal regulations governing Medicaid-funded Home and Community-Based Services (HCBS) authorized under Section 1915(c), Section 1915(i) and Section 1915(k) of the Social Security Act. The Federal HCBS Settings Rule focuses on two significant systems-change goals:

- Ensuring that individuals receiving HCBS through MaineCare, Maine’s Medicaid program, have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate to their needs; and
- Enhancing the quality of HCBS and simultaneously assuring HCBS recipients have key protections for certain rights, freedoms, and opportunities consistent with full access to the benefits of community living.

The Federal HCBS Settings Rule became effective on March 17, 2014, and requires states to demonstrate compliance in four key areas:

- Person-centered practices in the planning, case management/care coordination, and delivery of HCBS;
- Conflict-free case management protocols across Maine’s HCBS waivers to assure that each individual has the opportunity to participate in a conflict-free person-centered planning process that provides a free choice among qualified, willing providers of services for each of the member’s assessed needs without bias or undue influence in the planning process;
- Alignment of state Medicaid policies, regulations, and other standards to reflect compliance with the requirements set forth in the Federal HCBS Settings Rule; and
- Adherence to the settings standards and corresponding protections afforded to HCBS recipients across every Medicaid-funded setting providing HCBS.

These goals collectively reflect the most significant changes to Medicaid home and community-based services since section 1915(c) of the Social Security Act was passed by Congress in 1983, giving states the option to receive a waiver of Medicaid rules governing institutional care. Subsequent amendments of the Medicaid Act authorized state plan HCBS, also the subject of enhanced planning and settings requirements. As such, the Federal HCBS Settings Rule spurred a critical opportunity for states to focus on modernizing and strengthening systems-change efforts to assure that individuals are receiving the covered services they need and desire, from MaineCare-enrolled providers they choose, to support the life goals they have set for themselves, and to live, work, thrive and enjoy maximum independence and self-sufficiency in their homes and in typical community settings.

States now have until March 17, 2023 (Compliance Deadline) to assure that their regulations, policies, programs, and provider settings align and comply with the Federal HCBS Settings Rule

standards. States must submit a Final Statewide Transition Plan (STP) that describes the strategies, processes, and resources the state will deploy to complete all implementation efforts by the end of the transition period. The STP also is intended to serve as the state's roadmap for implementing the Federal HCBS Settings Rule and outlines a detailed work plan and timeline for ensuring that, as far as possible, all settings in which Medicaid HCBS services are provided comply with the new standards by the Compliance Deadline. The state's initial STP addressed the following:

- Accurate identification of all HCBS state authorities and settings impacted by the rule;
- A list and assessment of all state standards to determine areas where existing state regulations and policies were fully compliant, partially compliant, non-compliant or silent as they relate to one or more components of the Federal HCBS Settings Rule;
- Identification of strategies for remediating any areas of partial compliance; noncompliance or silence found during the systemic assessment of state standards; In
- Description of all key processes and milestones of the state's implementation strategy; and
- Description of stakeholder involvement in the development of the initial STP, including but not limited to affording stakeholders the opportunity to provide written formal comments on the initial STP during a public comment period.

The state's initial STP was posted for public comment from March 2, 2020 to March 31, 2020. After considering and responding to public comments, the state submitted the initial STP to CMS on April 17, 2020, and resubmitted the initial STP on May 27, 2020, revised to address CMS feedback. The state received CMS approval on May 28, 2020.

The state is required to submit this Final STP, updating the initial STP to describe any changes in the state's overall strategies, processes, and resources it will deploy to complete all implementation efforts by the Compliance Deadline. To this end, this Final STP includes:

- A comprehensive summary of completed site-specific assessments of all HCBS settings, validation of those assessment results, and the aggregate outcomes of these activities;
- A comprehensive summary of how the state identified HCBS settings presumed to have institutional characteristics, as well as the process used for evaluating these settings and preparing these settings for submission to CMS for heightened scrutiny review;
- Remediation strategies and a corresponding timeline for resolving non-compliance that the site-specific HCBS settings assessment process and subsequent validation strategies identified, by the Compliance Deadline;
- A process for communicating with MaineCare HCBS waiver participants currently receiving services in settings that the state determines cannot or will not come into compliance with the Federal HCBS Settings Rule standards by March 17, 2023;

- Plans for a safe and person-centered process to facilitate relocation of MaineCare HCBS waiver participants, if needed, to fully compliant HCBS settings by no later than March 17, 2023, to avoid loss of federal financial participation (FFP); and
- A description of ongoing monitoring and quality assurance processes that will ensure that all settings providing HCBS, including HCBS settings that were presumed to be compliant and therefore not included in the assessment, validation and transition-to-compliance activities outlined in this STP, continue to remain fully compliant with the Federal HCBS Settings Rule standards in the future.

Maine administers five Section 1915(c) HCBS waiver programs that are subject to the Federal HCBS Settings Rule.¹ The state of Maine is deeply committed to implementing the Federal HCBS Settings Rule requirements with fidelity, using the Federal HCBS Settings Rule as a catalyst for implementing other improvements to policy, payment, and practice associated with MaineCare HCBS, and improving access to and quality of HCBS services and options throughout the state. As such, the state has been working with stakeholders on additional systems-change efforts that complement the vision of the Federal HCBS Settings Rule (see section on “[Stakeholder Outreach and Engagement](#)”). The state is also making significant investments of new resources, available through the American Rescue Plan Act of 2021, to support HCBS providers in bringing their settings into full compliance. These efforts and investments are described in detail in the “Building Capacity of Providers” section of this plan.

The successful implementation of the Federal HCBS Settings Rule in the state of Maine is dependent upon the commitment of all stakeholders—state agencies with HCBS waiver oversight, participants in HCBS waiver programs, family members/caregivers, providers of HCBS, and direct support workforce professionals. The following Final Statewide Transition Plan lays out an in-depth strategy for engaging all stakeholders in each component of implementation to assure collective “ownership,” buy-in and accountability for increasing high-quality HCBS for older Americans and individuals with disabilities who receive MaineCare waiver services throughout the state.

¹ Maine’s state plan HCBS are not subject to the Federal HCBS Settings rule.

Introduction

This Final STP outlines the State of Maine’s strategic framework for implementing key aspects of the final federal regulation entitled, “[Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services \(HCBS\) Waivers](#)” (the Federal HCBS Settings Rule) published by the Centers for Medicare and Medicaid Services (CMS) in January 2014, and all subsequent directives and guidance specific to this regulation issued by CMS since January 2014.

The Federal HCBS Settings Rule established new standards for the provision of HCBS services, reinforcing the choice of HCBS participants to determine what services and supports they receive to live in their own homes and engage in community life. The Federal HCBS Settings Rule also defines standards for physical and programmatic characteristics of the settings in which HCBS may be provided, and affirms participant rights related to individual choice, autonomy, privacy, interaction with the broader community, and other protections. There are additional specific federal standards that apply to provider owned or controlled residential settings.

Maine, in turn, adopted a rule that applies the new federal requirements to HCBS providers in Maine: the Global HCBS Waiver Person-Centered Planning and Settings Rule, codified in 10-144 C.M.R. ch. 101 (the MaineCare Benefits Manual or “MBM”), Ch. I, Section 6 (the “Global HCBS Waiver Rule”). A copy of the Global HCBS Waiver Rule is enclosed with this final STP as Appendix XII. Maine’s Global HCBS Waiver Rule became effective as to all HCBS providers on January 19, 2022, except that settings approved prior to March 17, 2014 have until September 30, 2022 to comply with Subsection 6.04(A) and 6.04(B).

Summary of Required HCBS Settings Criteria outlined in the Federal HCBS Rule

Minimum Settings Criteria Expected of Settings Providing MaineCare Home and Community-Based Services

The Federal HCBS Settings Rule requires that all HCBS settings:

- Be integrated in and support full access of individuals receiving MaineCare HCBS (participants) to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community - to the same degree of access as individuals not receiving MaineCare HCBS.
- Allow the participant to select where s/he will receive HCBS from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be identified and documented in the Person-Centered

Service Plan and based on the participant's needs, preferences, and, for residential settings, resources available for room and board.

- Ensure a participant's rights of privacy, dignity and respect, and freedom from coercion and restraint including restrictive measures.
- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and deciding with whom to interact.
- Facilitate individual choice regarding HCBS waiver services and supports, and from among qualified and willing MaineCare providers.
- Comply with any and all applicable licensing requirements.

Additional Requirements for Provider Owned or Controlled Residential Settings

The Federal HCBS Settings Rule imposes the additional requirements for all provider owned or controlled residential settings, including the following:

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

- Each participant has privacy in their sleeping or living unit as evidenced by:
 - Units (including entrances, bedrooms, and bathrooms) have doors lockable by the member, with only appropriate staff having keys to doors
 - Participants sharing units have a choice of roommates in that setting
 - Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Participants have the freedom and support to control their own schedules and activities.
- Participants have access to food at any time.
- Participants are able to have visitors of their choosing at any time.
- The setting is physically accessible to the participant.

Requirements for Settings Providing MaineCare HCBS

All Settings Receiving Medicaid Funding for the Provision of MaineCare HCBS must:

- Be integrated in, and support access to, the greater community.

- Provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
- Ensure the participant receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services.
- Be selected by the participant from different setting options offered, including non-disability specific settings and an option for a private unit if the participant lives in a privately owned or controlled residential. The person-centered service plan must document the setting options offered based on the participant's needs and preferences, and for residential settings, the participant's resources.
- Ensure a participant's rights of privacy, dignity, respect, and freedom from coercion and restraint, including restrictive measures.
- Optimize individual initiative, autonomy, and independence in making life choices.
- Facilitate participant choice regarding services and supports, and who provides them.

Additional Standards that Apply to All Provider Owned or Controlled Residential HCBS Settings:

- The unit or dwelling is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the participant receiving services, and the participant has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and this legally enforceable lease or agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each participant has privacy in his or her sleeping or living unit as evidenced by:
 - Units (including entrances, bedrooms, and bathrooms) have doors lockable by the participant, with only appropriate staff having keys to doors as needed.
 - Participants sharing units have a choice of roommates in that setting.
 - Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - Participants have the freedom and support to control their own schedules and activities.
 - Participants have access to food at any time.
 - Participants are able to have visitors of their choosing at any time.
 - The setting is physically accessible to the participant.

Disability-Specific and Non-Disability-Specific Settings

Maine’s initial STP described the intent to apply the following additional standards applicable to provider owned or controlled residential settings, to settings determined to be provider owned or controlled non-residential settings:

- Participants have the freedom and support to control their own schedules and activities.
- Participants have access to food at any time.
- Participants may have visitors of their choosing at any time.
- The setting is physically accessible to the participant.

The state defined provider owned or controlled non-residential settings as those providing specified services under 10-144 C.M.R. ch. 101 – the MaineCare Benefits Manual (MBM):

- MBM Ch. II, Sec. 18 (Work Ordered Day Club House Services)
- MBM Ch. II, Sec. 20 (Work Support Services)
- MBM Ch. II, Sec. 21 (Community Support Services and Work Support-Group Services)
- MBM Ch. II, Sec. 29 (Community Support Services and Work Support-Group Services)

Based on public comments received in response to the state’s proposal of the Global Waiver HCBS Rule² for public comment from August 10 to September 16, 2021, the state is identifying these non-residential settings as “disability-specific settings.” Per Maine’s adopted Global HCBS Waiver Rule, “disability-specific setting” in this context means a non-residential HCBS setting that exclusively or primarily serves persons with a disability and that is not open to the general public.³ The Global HCBS Waiver Rule does not itself make these settings subject to the additional HCBS setting standards for provider owned or controlled residential settings, but expresses that in future waiver-specific rulemakings the Department may impose additional requirements relating to physical accessibility, visitors, choice of activities, and access to food. These settings must already meet other HCBS standards that indirectly address freedom to control schedules and activities, including the standards that require settings to optimize individual initiative, autonomy, and independence in making life choices. Importantly, physical accessibility for waiver participants is currently required in Sections 21 and 29 MaineCare rules:

Structures. The provider shall meet current requirements of the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. New construction, renovation, remodeling or repair shall be in full compliance with the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*.⁴

² MBM Ch. I, Sec. 6, Global HCBS Waiver Person-Centered Planning and Settings Rule.

³ MBM Ch. I, Sec. 6, Global HCBS Waiver Person-Centered Planning and Settings Rule, § 6.04(C).

⁴ MBM Ch. II, Sec. 21, § 21.18(6)(c) and Sec. 29, § 29.17(6)(b).

In addition, by statute, all settings receiving public funding are subject to the *Americans with Disabilities Act* as otherwise applicable.⁵ With regard to disability-specific residential settings, and for the purposes of ensuring choice of residential settings including a non-disability specific setting option, as required under the federal Rule,⁶ the state defines a disability-specific residential setting as:

- A setting that is provider owned or controlled; and
- A setting that is designed or designated as a setting exclusively for people with disabilities and/or other HCBS populations; and
- A setting (other than a single-family living unit) that is majority occupied by people with disabilities (and/or other HCBS populations) and paid staff delivering HCBS.

Correspondingly, a non-disability-specific setting is:

- A setting that is not provider owned or controlled; and
- A setting that is not designed or designated as a setting exclusively for people with disabilities and/or other HCBS populations; and
- A setting (other than a single-family living unit) that is not majority occupied by people with disabilities (and/or other HCBS populations) and paid staff delivering HCBS.

Modifications to Settings Standards: Person-Centered Planning Requirements

- Modifications of the additional settings standards that apply to provider owned or controlled residential settings are permitted, except: (1) the requirement that the HCBS participant have a legally enforceable lease or residency agreement; and (2) the requirement the setting be physically accessible to the HCBS participant.
- A modification may only be implemented if it is participant-specific and not applied across an entire setting. Allowable modifications of any standards must also be:
 - Supported by specific, individualized assessed need;
 - Justified in the person-centered service plan by documenting the prior interventions and supports, including the unsuccessful attempts to implement less intrusive methods;
 - Proportionate to the assessed need;
 - Documented in the person-centered service plan along with:
 - (1) a description of how the effectiveness of the modification will be measured and evaluated over time;

⁵ Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

⁶ 42 C.F.R. § 441.301(c)(4)(ii).

- (2) a schedule for ensuring time limits are placed on the modification with continuation subject to periodic review of the appropriateness of continuing the modification and lessening or eliminating the modification whenever possible;
- (3) informed consent of the participant (or legal guardian, if applicable);
- (4) assurance that interventions and supports will not cause harm.

HCBS Setting Standards that can be Modified for an HCBS Participant Due to a Documented and Justified Health and/or Safety Reason

Additional HCBS setting standards applying to provider owned or controlled residential HCBS settings that can be modified:

- Units (including entrances, bedrooms, and bathrooms) have doors lockable by the participant, with only appropriate staff having keys to doors as needed.
- Participants sharing units have a choice of roommates in that setting.
- Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Participants have the freedom and support to control their own schedules and activities
- Participants can have visitors of their choosing at any time.
- Participants have access to food at any time.

Differentiation of Settings receiving Medicaid funding for Long-Term Supports and Services under the Federal HCBS Rule

Institutional Settings

The Federal HCBS Settings Rule clarifies that the following settings are institutional settings (see Figure 3) and do not qualify to be providers of Medicaid-funded HCBS:

- Nursing facilities;
- Psychiatric in-patient facilities (Institutions for Mental Diseases or “IMDs”);
- Intermediate care facilities for individuals with intellectual disabilities (“ICF/IIDs”)
- Hospitals; and
- Other locations that have qualities of an institutional setting, as determined by the Secretary of the United States Department of Health & Human Services.

Presumed Institutional Settings

In addition, the Federal HCBS Settings Rule identifies three additional categories of settings that are presumed institutional in nature and thus are unlikely to meet some or all the Federal HCBS Settings Rule standards. These three categories of settings include:

- Prong 1: Any setting located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment;
- Prong 2: Any setting located in a building on the grounds of, or immediately adjacent to, a public institution; and
- Prong 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

The state of Maine’s existing policy categorizes these “presumed institutional” settings differently in that the state already has policy that defines the first two categories of presumed institutional settings to be institutional.

Figure 1. Federal and State Definitions for Institutional Settings

The Federal HCBS Settings Rule requires home and community-based services to be provided in a way that ensures people receiving HCBS have the same access, opportunities, and support to engage in similar life experiences as anyone not receiving HCBS. The Federal HCBS Settings Rule differentiates types of settings, with some determined to be ineligible for use in the provision of HCBS.

Institutional Settings

Applying the Federal HCBS Settings Rule standards and existing state policy, in the state of Maine, the following settings are considered to be institutions and thus are not eligible to receive Medicaid funding to provide HCBS:

- Nursing facilities;
- Psychiatric institutions (“IMDs”);
- Intermediate Care Facilities for Individuals with an Intellectual Disability;
- Hospitals;
- Any setting located in a publicly or privately operated facility that provides inpatient institutional treatment (e.g., a program or unit co-located with a *privately or publicly* operated nursing facility); and
- Any setting located on the grounds of, or immediately adjacent to, a public institution (e.g., a program sharing a campus with a *publicly* operated institution).

The state of Maine will continue to implement the state’s existing policy, and as such, any setting that is in the same building as a public or private institution (Prong 1), and any setting that is either adjacent to or on the grounds of a public institution (Prong 2) is considered to be institutional in nature and not qualified to provide MaineCare HCBS.

Presumed Institutional Settings Based on Isolating Determination

Prong 3 isolating settings are **presumed to be institutional** (i.e., presumed to have “institutional qualities”), and cannot be considered HCBS settings unless they undergo heightened scrutiny, as defined in the Federal HCBS Settings Rule, and demonstrate that they have addressed (or can address) their institutional characteristics and fully comply with all Federal HCBS Settings Rule standards. Per the federal regulation, any settings that possess characteristics that isolate individuals receiving HCBS from the broader community of individuals not receiving HCBS are presumed institutional in nature. The state followed CMS guidance regarding identification of settings that have an **isolating effect**:

CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid-funded 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* for interaction in and with the broader 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; or*
- *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.*

**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.*

Source: State Medicaid Directors Letter #19-001 issued 3/22/2019; Page 3.⁷

The entire process for identifying and addressing settings that isolate and are therefore subject to heightened scrutiny is detailed in [Overview of Heightened Scrutiny Process](#) section.

Provider Owned or Controlled Residential Settings

Provider owned or controlled residential settings are specific, physical places in which a participant resides that are owned, co-owned, and/or operated by a provider of home and

⁷ See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf> (accessed February 8, 2002).

community-based services. DHHS shall determine whether a setting is a provider owned or controlled residential setting when authorizing services for a participant at the setting.⁸

In the state of Maine, the following residential settings are considered provider owned or controlled:

- Group Homes (up to six people)
- Family-centered Homes (up to six people)
- Shared Living (Unrelated Provider)

All provider owned or controlled residential settings underwent a self-assessment process outlining where the providers felt they were following the Federal HCBS regulation and where remediation was needed. The Department and its contracted entity validated provider self-assessment results for each setting to assess compliance with all HCBS requirements through a process that was independent of the provider self-assessment process. For more information on the self-assessment and validation process, see [Overview of Maine's HCBS Setting Categories](#) section.

Settings Presumed Compliant with HCBS Requirements

Any settings that are not provider owned or controlled residential or disability specific non-residential settings, in which participants receive MaineCare HCBS in an individualized manner (i.e., on an individual basis) are considered typical community settings that may, according to federal regulation, be presumed to comply fully with the Federal HCBS Settings Rule standards. Residential settings that can be presumed compliant include a participant's private home, a residence the participant rents directly from a landlord that is not a provider of HCBS, or the home of an unpaid family member. Non-residential settings that can be presumed compliant include competitive integrated employment (Work Supports-Individual) settings, and integrated community settings where Community Support services are delivered on an individualized basis. While these settings do not require a provider self-assessment and independent validation for compliance with the HCBS settings standards during the state's transition-to-compliance period, these settings are required to be monitored by the state on an ongoing basis from 2023 to ensure HCBS participants receiving services in these settings have an experience that is consistent with HCBS Settings Rule standards. This is addressed in the [Ongoing Monitoring](#) section of this Plan.

Shared Living (Related Provider) Settings

Per direction from CMS, Shared Living (Related Provider) settings cannot be presumed compliant with HCBS requirements. While these arrangements are not considered provider owned or controlled, given the related family member is a paid provider, the State of Maine may

⁸ MBM Ch. I, Sec. 6, § 6.02(F).

not presume these settings to be compliant with HCBS requirements. Therefore, these settings went through the provider self-assessment process and then were validated by the state through a process that was independent of the provider's self-assessment process. The assessment and validation focused on the general HCBS requirements that apply to all settings and did not include the additional requirements specific to provider owned or controlled settings. For more information on the process of setting self-assessment and validation, see [Overview of Maine's HCBS Setting Categories](#) section.

Overview of MaineCare’s HCBS System & Infrastructure for Implementing the Federal HCBS Rule

The Medicaid Home- and Community-Based Services (HCBS) waiver program was authorized under Section 1915(c) of the Social Security Act. Through this program, states can help provide different services that allow those who need care and supports to receive these services in their homes or communities.

Under a waiver program, a state can seek and obtain federal approval to waive certain Medicaid program requirements, allowing the state to provide long-term services and supports (LTSS) for people who need them, including people who might not otherwise be eligible under Medicaid. Through certain waivers, states can target services to people who need LTSS. Waivers can be used along with other federal, state, and local programs, such as Medicaid State Plans, Vocational Rehabilitation programs, Special Education services, and Housing and Urban Development (HUD) programs, to name a few.

Overview of Maine’s Section 1915(c) HCBS Waiver Programs

Maine currently operates five federally approved Section 1915(c) HCBS waivers that must comply with the HCBS Settings Rule:

- Section 18 Home and Community-Based Services for Adults with Brain Injury (ME 1082);
- Section 19 Home and Community Benefits for the Elderly and for Adults with Disabilities (ME 0276);
- Section 20 Home and Community Services for Adults with Other Related Conditions (ME 0995);
- Section 21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder (ME 0159); and
- Section 29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME 0467).

Table 1 identifies these waiver programs by the section number for the part of the MaineCare Benefits Manual⁹ governing that waiver program. Throughout this Final STP, each waiver program is referred to by the relevant section number under the MaineCare Benefits Manual, with a shortened version of the waiver’s name, as indicated in the table below.

⁹ The MaineCare Benefits Manual can be accessed online at: <https://www.maine.gov/sos/cec/rules/10/ch101.htm>

Table 1. Maine's Approved Medicaid Section 1915(c) Waivers

Program	Initial Approval	Most Recent Renewal/ Amendment Date	Maximum Number of Participants
Section 18 Home and Community-Based Services for Adults with Brain Injury (ME 1082)	2014	7/1/19	250
Section 19 Home and Community Benefits for the Elderly and for Adults with Disabilities (ME 0276)	1994	7/1/18	2,665
Section 20 Home and Community Services for Adults with Other Related Conditions (ME 0995)	2013	7/1/18	67
Section 21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder (ME 0159)	1987	7/1/21	3,473
Section 29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME 0467)	2007	7/1/21	3,755

Each waiver serves specific populations eligible by diagnosis and age. Services include a broad range of services to support individuals to live and participate in typical community settings. The following provides a description of the populations that are eligible/served in each of MaineCare’s five waiver programs, as well as the services included under each waiver and the settings that are allowed to provide such services.

- **Section 18 Home and Community-Based Services for Adults with Brain Injury (ME 1082)**
 - Eligibility/Population Served: Individuals 18 years and older who have sustained an acquired brain injury.
 - Services include: Assistive Technology Device and Services, Care Coordination Service, Career Planning, Community/Work Reintegration, Employment Specialist Services, Home Support Services, Non-Medical Transportation Services, Self-Care/Home Management Reintegration, Work Ordered Day Club House, Work Support-Individual Services.
 - Settings: Community, Work, Residential (individual’s private home or Group Homes of 2-8 people), Club House.
- **Section 19 Home and Community Benefits for the Elderly and for Adults with Disabilities (ME 0276)**
 - **Eligibility/Population Served:** Elderly and disabled adults in order to avoid or delay nursing home placement or allow transition from nursing home to community.
 - Services include: Care Coordination, Assistive Technology, Attendant Services, Home Delivered Meals, Home Health Services, Living Well for Better Health, Matter of Balance, Personal Care Services, Personal Emergency Response Systems, Respite Services, Transportation Services, Environmental Modifications, and the use of a

Financial Management Service (FMS) and Skills Training for the Participant-Directed Option.

- **Settings:** Member's home.
- Section 20 Home and Community Services for Adults with Other Related Conditions (ME 0995)
 - **Eligibility/Population Served:** Individuals aged 21 or older with "other related conditions" (ORC) attributable to:
 - Cerebral Palsy or Epilepsy; or
 - Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disabilities and requires treatment or services similar to these required for these persons. These conditions include but are not limited to Neurofibromitosis, Other Chorea, Anoxic Brain Damage, Cerebral Laceration and Contusion, Subarachnoid- Subdural and Extradural Hemorrhage following injury, Other and Unspecified Intracranial Hemorrhage following injury or Intracranial injury and unspecified nature.
 - **Services Include:** Assistive Technology Device and Services, Care Coordination Services, Career Planning, Communication Aids, Community Support Services, Consultation Services and Assessment, Employment Specialist Services, Home Accessibility Adaptations, Home Support Services, Non-Traditional Communication Assessments, Non-Traditional Communication Consultation, Occupational Therapy (Maintenance) Services, Personal Care Services, Physical Therapy (Maintenance) Services, Specialized Medical Equipment, Speech Therapy (Maintenance) Services, Work Support-Individual Services.
 - **Settings:** Community, Work, Home Supports (members home or Group Homes (up to 4 ppl)).
- Section 21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder (ME 0159)
 - **Eligibility/Population Served:** 18 years or older, who have an Intellectual Disability (ID) or Autism Spectrum Disorder, or Rett Syndrome.
 - **Services include:** Assistive Technology, Communication Aids, Career Planning, Community Support, Counseling, Consultation Services, Crisis Assessment and Intervention Services, Employment Specialist Services, Home Accessibility Adaptations, Home Support-Agency Per Diem, Family-Centered Support, Home Support-Quarter Hour, Home Support-Remote Support, Non-Medical Transportation Service, Non-Traditional Communication Assessment, Maintenance-PT,

Maintenance-OT, Maintenance-Speech, Shared Living, Specialized Medical Equipment, Work Support-Individual, Work Support-Group.

- **Settings:** Community, Work, Shared Living (Related Provider), Shared Living (Unrelated Provider), Group Homes (up to 6 people), Family-Centered Homes (up to 6 people), Community Support, Work Support-Group
- Section 29 Support Services for Adults with Intellectual Disabilities or Autistic Disorder (ME 0467)
 - **Eligibility/Population Served:** 18 years or older, who have an Intellectual Disability (ID) or Autism Spectrum Disorder, or Rett Syndrome.
 - **Services include:** Assistive Technology, Career Planning, Community Support, Employment Specialist Services, Home Accessibility Adaptations, Home Support-Quarter Hour, Home Support-Remote Support, Respite Services, Non-Medical Transportation Service, Work Support-Group, Work Support-Individual, Shared Living.
 - **Settings:** Community, Work, Shared Living (Related Provider), Shared Living (Unrelated Provider), Community Support, Work Support-Group.

Table 2 outlines the eligibility/populations served, allowable services, and categories of settings permitted under each of Maine’s five Medicaid Section 1915(c) HCBS waivers.

Maine also has a Section 1115 demonstration waiver that provides case management and treatment to persons with HIV who would not otherwise be eligible for Medicaid. This demonstration program explicitly excludes HCBS and other LTSS as covered benefits and is therefore determined not subject to the Federal HCBS Settings Rule standards. There are no additional Maine HCBS waiver or Medicaid state plan amendment authorities that are subject to Federal HCBS settings standards.

Table 2. Maine HCBS Waivers by Population, Services, and Categories of Settings

Waiver	Eligibility	Services	Individualized Setting	Provider Owned or Controlled Residential Setting	Provider Owned or Controlled Non-Residential Setting
Section 18 Home and Community-Based Services for Adults with Brain Injury* (ME 1082)	Individuals 18 years and older who have sustained an acquired brain injury.	Assistive Technology Device and Services, Care Coordination Service, Career Planning, Community/Work Reintegration, Employment Specialist Services, Home Support Services, Non-Medical Transportation Services, Self-Care/Home Management Reintegration, Work Ordered Day Club House, Work Support-Individual Services.	Individual’s Private Home Work Support-Individual	Group Homes (2-8 people)	Club House
Section 19 Home and Community Benefits for the Elderly and for Adults with Disabilities (ME 0276)	Elderly and disabled adults in order to avoid or delay nursing home placement or allow transition from nursing home to community.	Care Coordination, Assistive Technology, Attendant Services, Home Delivered Meals, Home Health Services, Living Well for Better Health, Matter of Balance, Personal Care Services, Personal Emergency Response Systems, Respite Services, Transportation Services, Environmental Modifications, and the use of a Financial Management Service (FMS) and Skills Training for the Participant-Directed Option.	Individual’s Private Home		
Section 20 Home and Community Services for Adults with Other Related Conditions (ME 0995)	Individuals age 21 or older with “other related conditions” (ORC) attributable to: Cerebral Palsy or Epilepsy; or Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disabilities and requires treatment or services similar to these required for these persons. These conditions include but are not limited to Neurofibromitosis, Other Chorea, Anoxic Brain Damage, Cerebral Laceration and Contusion, Subarachnoid-Subdural and Extradural Hemorrhage following injury, Other and Unspecified Intracranial Hemorrhage following injury or Intracranial injury and unspecified nature.	Assistive Technology Device and Services, Care Coordination Services, Career Planning, Communication Aids, Community Support Services, Consultation Services and Assessment, Employment Specialist Services, Home Accessibility Adaptations, Home Support Services, Non-Traditional Communication Assessments, Non-Traditional Communication Consultation, Occupational Therapy (Maintenance) Services, Personal Care Services, Physical Therapy (Maintenance) Services, Specialized Medical Equipment, Speech Therapy (Maintenance) Services, Work Support-Individual Services.	Individual’s Private Home Work Support-Individual	Group Homes (up to 4 people)	Community Supports

Table 2. Maine HCBS Waivers by Population, Services, and Categories of Settings (continued)

Waiver	Eligibility	Services	Individualized Setting	Provider Owned or Controlled Residential Setting	Provider Owned or Controlled Non-Residential Setting
Section 21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder (ME 0159)	18 years or older, who have an Intellectual Disability (ID) or Autism Spectrum Disorder, or Rett Syndrome	Assistive Technology, Communication Aids, Career Planning, Community Support, Counseling, Consultation Services, Crisis Assessment and Intervention Services, Employment Specialist Services, Home Accessibility Adaptations, Home Support-Agency Per Diem, Family-Centered Support, Home Support-Quarter Hour, Home Support-Remote Support, Non-Medical Transportation Service, Non-Traditional Communication Assessment, Maintenance-PT, Maintenance-OT, Maintenance-Speech, Shared Living, Specialized Medical Equipment, Work Support-Individual, Work Support-Group.	Community Generic Work Setting Shared Living (Related Provider)**	Shared Living (Unrelated Provider) Group Homes (up to 6 people) Family-Centered Homes (up to 6 people)	Community Support Work Support-Group
Section 29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME 0467)	18 years or older, who have an Intellectual Disability (ID) or Autism Spectrum Disorder, or Rett Syndrome	Assistive Technology, Career Planning, Community Support, Employment Specialist Services, Home Accessibility Adaptations, Home Support-Quarter Hour, Home Support-Remote Support, Respite Services, Non-Medical Transportation Service, Work Support-Group, Work Support-Individual, Shared Living.	Individual’s Private Home Work Support-Individual Shared Living (Related Provider)	Shared Living (Unrelated Provider)	Community Support Work Support-Group

State Infrastructure to Support Federal HCBS Rule Implementation

The Office on Aging & Disability Services (OADS) serves as the lead agency within DHHS for implementing Maine’s Final STP. DHHS also convened an Executive Steering Committee (ESC) to provide strategic oversight of the state’s implementation activities to ensure MaineCare’s HCBS programs are in full compliance with the Federal HCBS Settings Rule, and MaineCare HCBS settings are in full compliance with Maine’s Global HCBS Waiver Rule.

The ESC includes twenty-four (24) members with representation from the DHHS Commissioner’s Office, DHHS Office Directors or their designees, program subject matter

experts within the Office of Aging and Disability Services (OADS), the Office of MaineCare Services, and the Division of Licensing and Regulatory Services. The ESC oversees the state's transition-to-compliance initiative, reviews the recommendations of the Stakeholder Advisory Committee, reviews/approves the work products of staff and consultants, and receives and decides upon recommendations of staff and consultants regarding the state's implementation of the Federal HCBS Settings Rule. The ESC meets on a monthly basis and has been meeting since June 2019.

Achieving full compliance with the Federal HCBS Settings Rule has proven complex and challenging but is a critically important process to advance the DHHS's goal of including HCBS participants in their communities. Time was lost when the previous administration paused the state of Maine's work to develop and implement a transition-to-compliance process and initial STP reflective of this; but the effort got back on track in June of 2019 with an ambitious but achievable workplan and timeline for achieving full statewide compliance by the federal deadline for all states which at that time was March 2022. The state's initiative was then further delayed as a result of the COVID-19 pandemic and public health emergency (PHE). CMS responded to COVID-19 by extending the deadline to March 2023 for all states to achieve full compliance. However, the benefit of the additional year was soon lost when the State had no choice but to pause the process multiple times due to the impact of COVID-19 on providers and safety risks posed by settings validation strategies. Process pauses and the impact on validation activities are discussed in more detail in [Impact of COVID 19 on Validation Schedule and Methods](#) section. Consequently, Maine's transition-to-compliance timeline remains extremely tight. However, the transition-to-compliance workplan and timeline (see Appendix VIII) for ensuring the state meets the new federally mandated deadline of March 17, 2023 remains achievable if no further delays to the process occur.

DHHS appreciates the assistance and cooperation it continues to receive from partner agencies, providers, and other stakeholders to establish, refine and continue to implement an ambitious and thorough plan for how to achieve full compliance by March of 2023. By achieving this, the State will be able to preserve its continued and uninterrupted access to over \$412 million dollars annually in federal matching funds, representing approximately 64% of the total funding currently utilized to operate Maine's five HCBS waivers. Nothing can preserve the health, safety and security of Maine's citizens receiving HCBS waiver services more than preserving this federal funding by achieving full compliance with the HCBS Settings Rule by March of 2023.

Collective Action & Accountability for Maine’s HCBS Systems-Change Work: Stakeholder Outreach and Engagement

In order to realize the aims of the Federal HCBS Settings Rule and Maine’s own goals for improving access to and quality of home and community-based services (HCBS) in the state, active and meaningful engagement with all stakeholders continues to be essential to our collective success.

DHHS has utilized multiple strategies for informing and engaging stakeholders about the Federal HCBS Settings Rule and the implications for Maine, for responding to questions and concerns, and to solicit input on the preliminary and ongoing assessment of the HCBS system’s compliance. These strategies include:

- hosting informational webinars;
- sponsoring community forums and town hall sessions;
- convening a Stakeholder Advisory Committee to provide ongoing feedback on the state’s approach to implementation of the Federal HCBS Settings Rule;
- conducting six public comment periods; and
- conducting six public hearings

DHHS also has established a web-page specific to the Federal HCBS Settings Rule (<https://www.maine.gov/dhhs/oads/hcbs/index.shtml>) and its transition-to-compliance initiative. The webpage contains sub-pages linking to information on the HCBS Rule overview and milestones; stakeholder advisory committee; public hearings and comments; and training and resources. DHHS also created a dedicated email address at hcbs.dhhs@maine.gov. In addition, DHHS sends regular communications through list serves and other electronic media.

The following section summarizes the public engagement activities completed from 2014-2021 and outlines the state’s plans for additional activities in 2022 and 2023. The state is committed to continuing ongoing engagement of stakeholders in the implementation of the remainder of this statewide transition plan.

Outreach and Informational Webinars

In October 2014, DHHS initiated a public education and outreach campaign by disseminating a notice about a series of four (4) informational webinars targeting the four primary audiences identified in Table 3 below. Since the state restarted its efforts in late 2019, after an administration change, DHHS has hosted an additional five (5) informational webinars to provide an update to, and receive feedback from, stakeholders on the state’s plan for developing and implementing a comprehensive approach to achieving full compliance with the Federal HCBS Settings Rule standards. DHHS also posted a recorded introductory training webinar on

the HCBS Settings Rule for all stakeholders in October 2019.¹⁰ In addition, Disability Rights Maine hosted an informational webinar for waiver participants, family members, guardians and advocates in January 2020 and posted a recorded informational webinar on YouTube for this audience in February 2021.¹¹ All of these webinars are also reflected in Table 3.

Note: As the state began implementation of its transition-to-compliance initiative, more than thirty (30) different webinars for providers and case managers occurred that had multiple purposes including sharing information, training, technical assistance and obtaining feedback. These webinars are not included in Table 3 but are discussed in detail in the section of this Plan entitled [Building Capacity of Providers and Front-line Staff in Person-Centered, Individualized HCBS Delivery](#).

Table 3. List of HCBS Rule Outreach and Informational Webinars Hosted by State of Maine for Stakeholders (2014-2021)

Audience	Program	Date
Waiver Participants & family members, guardians, Advocates	Any	10/27/14
		10/2019
		1/27/20*
		1/28/21
		1/29/21
Service providers	Section 18, adults with brain injury Section 20, adults with other related conditions	2/22/21*
		10/28/14
Service providers	Section 19 and Section 22, older adults & adults with physical disabilities	10/29/14
Service providers	Section 21 and Section 29, adults with intellectual disability or autism	10/31/14
Case Managers & Care/ Service Coordinators	All case management personnel across MaineCare’s five HCBS waivers	2/13/20
Service providers	Any	10/2019
		1/29/20

**Conducted by Disability Rights Maine.*

Notice of these webinars was disseminated through the listservs of the Office of Aging and Disability Services (OADS) and the Office of MaineCare Services (OMS) and posted on OADS

¹⁰ <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/HCBS-Settings-Rule-10-2019.pptx> (accessed February 1, 2022).

¹¹ <https://www.youtube.com/watch?v=ZmaSSV4CJpU&t=1076s> (accessed February 1, 2022).

website.¹² Meeting materials providing an overview of the Federal HCBS Settings Rule were also posted on OADS' website.¹³ Stakeholders were invited to ask questions during the webinars, by contacting DHHS leads, or by submitting questions. The meeting materials included phone numbers and email addresses for DHHS leads as well as OADS' general email address for submitting questions.¹⁴

State Community Forums

Since 2014, OADS has also completed additional outreach and engagement by hosting a community forum in 2014, followed by three town hall sessions in 2019.

Community Forum (December 19, 2014)

OADS issued a notice of a community forum to be held on December 19, 2014. Notice of the public forum was published in the legal notice section of five major newspapers,¹⁵ disseminated through the OADS listserv, and posted on the OADS website. On December 15, 2014, OADS posted a draft of this Transition Plan on its website¹⁶ and disseminated it through the OADS listserv.

The statewide community forum took place on December 19, 2014. It was open to the public, linking multiple sites (the University of Maine at Augusta, the University of Maine at Orono, the University of Maine at Presque Isle, the University of Maine at Fort Kent, and the University of Southern Maine) through interactive video conferencing. Twenty-five people participated in person across all five sites, and 100 people listened in by phone.

The purpose of the forum was to provide an opportunity for a two-way dialogue about the Transition Plan, providing stakeholders the opportunity to ask questions about it and an informal forum for voicing their concerns. The forum also provided Department staff an opportunity to

¹² Now archived OADS News page providing an overview of the new rule and announcing the webinar: <http://www.maine.gov/dhhs/oads/aging/news-details.shtml?id=629500> (accessed November 3, 2014) and current OADS HCBS initiative page: <https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs>.

¹³ Now archived OADS News page posted October 22, 2014 and providing information about informational sessions and links to meeting materials: <http://www.maine.gov/dhhs/oads/aging/news-details.shtml?id=630012> (accessed February 27, 2015) and current OADS HCBS initiative training and resources page: <https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources> (accessed February 1, 2022).

¹⁴ DHHS is unable to report on the specific number of stakeholders participating in these webinars.

¹⁵ Notice of the community forum was printed in the legal notice section of these newspapers: on Sunday, December 14, 2014, the Portland Press Herald/Maine Sunday Telegram, the Sun Journal, the Kennebec Journal, and the Morning Sentinel; and on Monday, December 15, 2014: the Bangor Daily News. The content of the published notice may be viewed in the Appendix on page 64.

¹⁶ The draft Transition Plan was posted on OADS HCBS Regulatory Updates page located at: <http://www.maine.gov/dhhs/oads/initiatives/HomeandCommunityBasedServicesRegulation2014.htm>.

clarify their own understanding of stakeholder concerns. The dialogue was informal. Questions and concerns were noted but not recorded as formal comments.

Participants were invited to submit informal written questions and comments by December 31, 2014, prior to the initiation of the formal public comment period. Informal questions and comments have been addressed in DHHS's response to comments, below. DHHS received informal written questions and comments from a total of three members of the public.

In response to requests from stakeholders, DHHS also produced a plain language version of the Transition Plan, which was disseminated on January 15, 2015, as well as graphical representation of the objectives of the Transition Plan, which was posted on January 16, 2015.

Community Forum Series (October 28-30, 2019)

In October of 2019, the state hosted a three-part community forum series (also referred to as town hall sessions) for stakeholders to hear about the revitalized efforts of the state and to provide feedback into strategies for how the state should approach its assessment and remediation of state rules, policies and standards to comply with the Federal HCBS Settings Rule, as well as assessing, validating and remediating all HCBS settings to assure full compliance with the Federal HCBS settings standards. These sessions were hosted as follows:

- **October 28th 3-5pm Houlton**, UMPI Houlton Campus, 18 Military St. Rm.109/110
- **October 29th 3-5pm Portland**, USM Abromson Education Center at Hannaford Hall at 88 Bedford Street, 2nd Floor, Room 214/215
- **October 30th 3-5pm Augusta**, UMA, The Fireside Lounge, Randall Student Technology Center

Both an in-person and call-in option was made available for each session to allow multiple vehicles for stakeholder engagement. While not recorded as formal comments, questions and concerns were noted and used to inform additional stakeholder education strategies.

Stakeholder Advisory Committee Meetings

DHHS established a Stakeholder Advisory Committee (SAC) to ensure the state develops and implements a comprehensive plan to transition its HCBS programs and settings to full compliance with the federal regulations.

The Stakeholder Advisory Committee (SAC) is a diverse stakeholder committee comprised of waiver program participants, self-advocates, providers, advocates, family members, and other experts in their fields. Members are appointed by the DHHS Commissioner to engage over the course of the transition-to-compliance initiative. The original SAC, including 16 members, met on December 29, 2015. The Committee was then dismantled but re-established in 2019 when the State restarted its transition-to-compliance initiative. Members appointed in 2019 were asked to

commit to what was initially a three-year process (2019 to 2022) that has now been extended to 2023.

The SAC meets quarterly, receives regular updates on the progress of the state's transition-to-compliance initiative, provides recommendations to the ESC, staff and consultants on operational, procedural and outreach/educational activities related to all transition-to-compliance efforts. Examples include reviewing materials and sending feedback via electronic mail as well as at in-person (prior to COVID-19) quarterly meetings and virtual quarterly meetings since COVID-19.

The primary role of the SAC is to provide subject matter expertise and insights specific to the perspectives of various stakeholders (particularly self-advocates, family members and providers) on implementing the Federal HCBS Settings Rule. A parent member of the SAC co-chairs the SAC along with the OADS HCBS initiative manager. Other OADS staff members with leadership roles on the transition-to-compliance initiative attend the SAC and ensure SAC recommendations and feedback is shared with the ESC. Representatives from the following organizations participate on the SAC:

- Disability Rights Maine (2)
- Maine Association of Community Service Providers (4)
- Developmental Disabilities Council (1)
- Speaking Up for Us (5)
- Maine Association of Area Agencies on Aging (1)
- Maine Developmental Service Oversight and Advisory Board (1)
- Maine Long Term Care Ombudsman Program (1)
- Brain Injury Association of America (1)
- Behavior Analyst (1)
- Family Members (2)

The SAC has met eleven times in since June of 2019 and will continue to meet quarterly throughout the duration of the transition period until March 2023. In order to capture feedback from the SAC during key aspects of the implementation process in real-time, the state also hosts virtual discussions among SAC members in-between the regular quarterly meetings. Thus far, three of these interim SAC meetings have been held for the purposes of allowing the SAC an opportunity to preview and offer feedback on both the Initial and Final STPs. All virtual meetings are web-based and fully accessible to all SAC members. Appendix I includes in-person and virtual meeting summaries from June 2019 to March 2022.

Monthly Provider Engagement Webinars

Beginning in January 2020, the state began hosting a monthly virtual webinar series for HCBS providers to collaborate on key topics related to effective implementation of the HCBS rule. A primary focus of this webinar series is providing a venue for providers to receive information they are requesting, to give provider an opportunity to ask questions and share concerns and recommendations, and to provide opportunities for providers to hear from each other on strategies they are using to bring their settings into full compliance. All monthly webinars are recorded, and the recording is posted on the OADS website and in the HCBS Compliance Portal training and resources page. It has been typical to have over 200 participants in these monthly webinars, which will continue through the end of the transition period.

Opportunity for Formal Comments

The Office of MaineCare Services has invited members of the public to provide formal comments on versions of the statewide transition plan three times since 2014.

2014 Public Comment Period & Public Hearing

On December 31, 2014, OMS provided legal notice of a public hearing and an opportunity to submit formal comments by publishing notice in five major newspapers and posting an announcement on the OMS' Policies and Rules webpage.¹⁷ The published notice provided a link to the OMS webpage for obtaining a copy of the initial statewide transition plan (STP) and for submitting public comments. Persons visiting the OMS webpage could download a copy of the draft initial STP, a graphical representation of the initial STP, and obtain information for viewing a copy of the initial STP at any of DHHS's regional offices or obtaining a printed copy from OMS. The draft initial STP was posted on the Office of MaineCare Services Policies and Rules webpage December 31, 2014.¹⁸

A public hearing complying with Maine's Administrative Procedures Act (APA) was held January 16, 2015. Testimony from five members of the public was received and recorded, and a formal summary of the hearing proceedings is in Appendix III. Formal written comments were accepted through January 31, 2015. A total of ten formal written comments were received by the January 31, 2015 deadline. The public notice, a summary of the ten public comments received, as well as an initial set of responses from the state in January 2015, are in Appendix III. It is important to note, however, that MaineCare's statewide transition plan for implementing the Federal HCBS Settings Rule has evolved dramatically since the time of the 2015 public

¹⁷ See Appendix III for information on the newspapers in which notice was published and the notice content.

¹⁸ The URL for the Statewide Transition Plan posting on OMS' webpage page is: <http://www.maine.gov/dhhs/oms/rules/transition-plan.shtml>. The notice on OMS' webpage may be viewed at this site or in Appendix III.

comment process, so the state's initial responses may be outdated or may not reflect the state's current thinking.

2020 Public Comment Period & Public Hearing

In March 2020, the state of Maine issued a second request for public comment to seek feedback from members of the public and key stakeholders about the state's refined initial statewide transition plan (STP). On March 2, 2020, OMS provided legal notice of a public hearing and an opportunity to submit formal comments by publishing notice in three major newspapers (Lewiston-Sun Journal, Kennebec Journal, and the Portland Press Herald) and posting an announcement on the OMS' Policies and Rules webpage.¹⁹ Additionally, the state issued notification letters to each major tribal organization in the state. The published notices provided a link to the OMS webpage for obtaining a copy of the Transition Plan and for submitting public comments. Persons visiting the OMS webpage could download a copy of the draft Transition Plan and obtain information for viewing a copy of the Transition Plan at any of DHHS's regional offices or requesting a printed copy from OMS. The public comment period closed on March 31, 2020.²⁰

A public hearing complying with Maine's Administrative Procedures Act (APA) was held March 12, 2020. Testimony from three members of the public was received and recorded, and a formal summary of the hearing proceedings is in Appendix III.3. Formal written comments were accepted through March 31, 2020. A total of ten formal written comments were received by the March 31, 2020, deadline. The public notice, a summary of all public comments received, as well as an initial set of responses from the state, are also included in Appendix III.4.

Summary of Changes to the March 2020 Proposed Initial Statewide Transition Plan Made in Response to Comments

In response to comments received in January 2015 and March 2020, feedback from the Centers for Medicare & Medicaid Systems (CMS), and input from the Stakeholders Advisory Committee, DHHS made several clarifications and substantive changes to the initial STP, prior to submission to CMS for approval. These changes included:

- Clarifying that the state will apply the HCBS standards to all of Maine's waivers.
- Clarifying the relationship between the Federal HCBS Settings Rule standards and DHHS's plans for strengthening the person-centered planning process and access to the community for persons living at home.

¹⁹ See Appendix III for information on the newspapers in which notice was published and the notice content.

²⁰ The URL for the Transition Plan posting on OMS' webpage page is: <http://www.maine.gov/dhhs/oms/rules/transition-plan.shtml>. The notice on OMS' webpage may be viewed at this site or in Appendix III.4.

- Expressing intent to develop both a global HCBS regulation and legislative proposal to assure a consistent reflection of federal and state HCBS requirements across MaineCare's five HCBS waivers.
- Clarifying the state's intent with respect to submitting evidence to CMS for those settings presumed to be institutional by virtue of having characteristics that isolate members receiving Medicaid-funded HCBS from the greater community of individuals not receiving Medicaid-funded HCBS. DHHS will only submit packages for those settings that it believes have addressed or can address, within the allowable timeframes, all isolating characteristics and can fully comply with the HCBS standards.
- Modifying the STP to expand the setting assessment and validation processes to include all disability-specific, non-residential settings.
- Modifying the STP to more clearly articulate a stakeholder process that incorporates stakeholder input throughout the implementation phase.
- Incorporating the input of multiple parties in designing the on-site validation sampling methodology.
- Using responses from the initial provider self-assessments to identify trends in gaps in compliance across waiver programs and categories of settings and planning technical assistance and additional training opportunities for providers to address such challenges.
- Expanding the state's initial plans for validating settings that assures that each setting is independently validated.

Additionally, from 2013-2016, Maine participated in the Employment First Leadership Mentoring Program (EFSLMP) funded by the Office of Federal Employment Policy at the U.S. Department of Labor. Through that technical assistance program, Dr. Lisa Mills (one of the five subject matter experts chosen to assist Maine), who now has lead SME responsibility for helping Maine to develop and implement its HCBS statewide transition plan, drafted a report providing guidance on policy decisions Maine could consider to ensure competitive integrated employment opportunities and supports are more readily available to persons receiving HCBS services. Her report was received February 16, 2015 and posted on the OADS' news webpage²¹ and on OADS' HCBS Regulatory Updates webpage. Dr. Mills' recommendations were considered in revisions made to the initial statewide transition plan in 2015 and have been carried over into subsequent versions of the STP.

²¹ This document may be accessed on the OADS home page (<http://www.maine.gov/dhhs/oads/index.shtml>) and its HCBS Regulatory Updates page (<http://www.maine.gov/dhhs/oads/initiatives/HomeandCommunityBasedServicesRegulation2014.htm>).

Other Changes to the March 2020 Proposed Initial Statewide Transition Plan

In addition to the changes made in response to public comments, the following changes were made in response to corrections and comments of Departmental staff:

- Creation of additional educational and informational resources written in such a manner as to be easily digestible for participants and their families to learn about the state and Federal HCBS requirements and the rights afforded to them under the 2014 regulation.
- Corrections relating to data for and characterization of Work Support settings.
- Updates for enrollments in all five HCBS waivers.
- Revisions to initial systemic findings and completion of comprehensive review of all relevant state standards.
- Enhancements to state HCBS systemic remediation strategy to include intent to develop a state global HCBS regulation and legislative proposal.
- Summary of provider self-assessment results.
- Additions to protocols outlined with respect to setting assessment, validation and remediation.
- Outline of process for heightened scrutiny, ongoing monitoring, and relocation of beneficiaries out of settings that cannot reach compliance by March 17, 2023.
- Description of investments state is making in building the capacity of providers to expand offerings in non-disability specific settings.

Submission of Initial Statewide Transition Plan to CMS and Receipt of Approval

On April 23, 2020, DHHS submitted the final version of the Initial STP to CMS for approval. CMS provided feedback to DHHS on May 13, 2020, requesting that the state make several technical corrections in order to receive initial approval. CMS confirmed that these changes did not necessitate another public comment period. DHHS addressed all of the issues and resubmitted an updated version on May 26, 2020. CMS granted initial approval on May 28, 2020. Both the Office of MaineCare Services (OMS) and the Office of Aging and Disability Services (OADS) posted the CMS approval letter and approved initial STP on their respective webpages.²²

²² <https://www.maine.gov/dhhs/oms/about-us/policies-rules/proposed-and-recently-adopted/statewide-hcbs-transition-plan>; <https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/transition-plan-overview> (accessed February 1, 2022).

2022 Public Comment Period & Public Hearing on the Draft Final Statewide Transition Plan

Between April 20 and May 20, 2022, the state of Maine is accepting public comment on the draft Final STP as a means to seek additional feedback from members of the public and key stakeholders. On April 14, 2022, OMS provided legal notice of a public hearing and an opportunity to submit formal comments by publishing notice in three major newspapers (Lewiston-Sun Journal, Kennebec Journal, and the Portland Press Herald) and posting an announcement on the OMS' Policies and Rules webpage.²³ Additionally, the state issued notification letters to each major tribal organization in the state. The published notices provided a link to the OMS webpage for obtaining a copy of the draft Final STP and for submitting public comments. Persons visiting the OMS webpage can download a copy of this draft Final STP and obtain information for viewing a copy of the draft Final STP at any of DHHS's regional offices or requesting a printed copy from OMS. The public comment period will close on May 20, 2022.²⁴

A public hearing complying with Maine's Administrative Procedures Act (APA) is scheduled for May 10, 2022. Testimony from members of the public will be received and recorded, and a formal summary of the hearing proceedings will be included in Appendix III. Formal written comments will be accepted through May 20, 2022. A summary of the public comments received, as well as a set of responses from the state, will be included in Appendix III and the State will take account of public comments in finalizing this Final STP prior to submission to CMS for approval. Any changes required by CMS will be made by the State, as needed, to facilitate federal approval.

Building Capacity of HCBS Program Delivery Consistent with the Requirements of MBM Ch. I, Section 6

DHHS has and will continue to support collaboration and provide training and technical assistance to improve and expand the capacity of HCBS programs to bring settings into full compliance with Maine's Global HCBS Waiver Planning and Settings Rule, 10-144 C.M.R. ch. 101, Ch. I, Sec. 6. DHHS invested in the development of an online HCBS Compliance Portal for providers to securely receive and submit all information related to the settings transition-to-compliance process. The Portal is supported by a contracted subject matter expert (SME) team from Economic Systems, Inc. (EconSys) and a technical help desk team that works

²³ Before final submission of this STP to CMS, Appendix III will include information on the newspapers in which notice was published and the notice content.

²⁴ The URL for the Transition Plan posting on OMS' webpage page is: <http://www.maine.gov/dhhs/oms/rules/transition-plan.shtml>. The notice on OMS' webpage may be viewed at this site and will be included in Appendix III before final submission of this STP to CMS.

collaboratively with OADS to provide ongoing support, training and technical assistance to all providers.

Provider Training & Technical Assistance

Monthly Provider Webinars

As noted previously, beginning in January 2020, the state began hosting a monthly virtual webinar series for HCBS providers on key topics related to effective implementation of the HCBS rule. A key focus of this webinar series is providing timely information and training, opportunities for providers to ask questions, and opportunities for providers to hear from each other on strategies they are using to bring their settings into full compliance. All monthly webinars are recorded and the recording as well as the PowerPoint presentation is posted on the OADS website and in the HCBS Compliance Portal training and resources page. It has been typical to have over 200 participants in these monthly webinars, which will continue through the end of the transition period.

Trainings on HCBS Modifications for Case Managers and Providers

DHHS developed specific training for providers and case managers to ensure correct implementation of HCBS modifications. To implement modifications consistent with Maine's Global HCBS Waiver Rule, the state designed and implemented an HCBS Rights Modifications Addendum to the Person-Centered Plan. A customized version of the Addendum was created for each HCBS Waiver that utilizes provider owned or controlled residential settings: Section 18 Waiver; Section 20 Waiver; and Section 21/29 Waivers. The Addendums were rolled out through training provided in January 2021 to three target audiences: (1) Case Managers and state staff; (2) HCBS providers; and (3) Participants and allies including families and legal guardians. The trainings introduced: the HCBS planning requirements; provisions for modifications of some requirements; the Addendums necessary to implement a modification for a participant; and decision-trees for each impacted HCBS Waiver to aid in correct implementation of modifications using the Addendums. Additionally, necessary adjustments were made to existing forms including the Positive Support Plan, Behavior Management Plan, In-Home Stabilization Template and the Safety Device Plan. These resources were updated in March of 2022 to align with the state's Global HCBS Waiver Rule and can be found at the following links:

- For the Section 18 Waiver
 - The HCBS Rights Modification Addendum for Section 18, Decision Tree, and Updated Brain Injury Waiver Behavior Plan Review Form is posted under "Providers" tab: <https://www.maine.gov/dhhs/oads/providers/adults-with-brain-injury>

- For the Section 20 Waiver
 - The HCBS Rights Modification Addendum for Section 20 and Decision Tree is posted under “Providers” tab: <https://www.maine.gov/dhhs/oads/providers/adults-with-cerebral-palsy-seizure-disorder-other>
- For the Section 21/29 Waivers
 - Updated Behavior Regulation forms for adults with ID/Autism is posted here: <https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism/behavioral-regulation>
- The HCBS Rights Modification Addendum for Sections 21 and 29 and Decision Tree is posted on the Forms and Protocols page under “Person-Centered Planning Forms”: <https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism>

The state also posted all three of the HCBS Rights Modification Addendums (S.18, S.20, S.21/29) and Decision Trees to the OADS HCBS Training and Resources page under Case Manager Resources tab. See updated versions at: <https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources>. An HCBS Modifications FAQ resource and an HCBS Modifications Knowledge Check for case managers to ensure accurate understanding after the training, updated in March 2022 to reflect the state’s Global HCBS Waiver Rule, can also be found at: <https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources>.

The state provided guidance that, between February 1, 2021, and May 31, 2022, all HCBS modifications deemed to be necessary during the process of person-centered planning must be incorporated into person-centered plans, using the appropriate HCBS Rights Modification Addendum. This must be done when a participant’s person-centered plan is due for development or update between February 1, 2021, and May 31, 2022, ensuring the participant (or legal guardian if applicable) gives consent for any HCBS modification, as well as the involvement of the person-centered planning team.

Training on Ensuring Choice of Non-Disability-Specific Settings for Case Managers and Providers

The state’s Global HCBS Waiver Rule requires that HCBS participants have a choice regarding the setting(s) where they receive services, including the choice of a [non-disability-specific setting](#). Successful implementation requires a collaborative effort on the part of Care Coordinators/Case Managers and other service providers. To assure fidelity in implementation of this requirement, OADS developed training for Care Coordinators/Case Managers and other HCBS providers. The choice of settings is made in the person-centered planning process²⁵.

²⁵ 42 C.F.R. § 441.301(c)(1)(ix).

Provider owned or controlled settings are expected to be selected by the participant from among setting options including non-disability specific settings.²⁶ To ensure strong collaboration regarding choice of settings, particularly ensuring non-disability-specific settings are offered as options, OADS developed training for Care Coordinators/Case Managers and Providers on this requirement and how to effectively address it for each HCBS participant. These trainings were provided in January 2021 and were recorded and posted online.

Other Topic-Specific Training Series

OADS has hosted multiple topic-specific training series in virtual formats using national expert presenters. Dr. Angela Amado²⁷ presented a training series on facilitating community connections and supporting relationship building for HCBS participant. Genni Sasnett²⁸ presented a training series on provider agency transformation and how Community Support services can be a pathway to integrated employment and full community engagement. Both of these series and all of the resources shared are posted on the OADS HCBS webpage.

DHHS, OADS, Maine Department of Labor, Maine Vocational Rehabilitation, Maine APSE, and Employment First Maine have collectively hosted multiple training opportunity to support providers in ensuring HCBS participants have access to integrated employment opportunities and supports. OADS added an integrated employment module to the College of Direct Supports platform for direct service professionals to support providers to meet the expectation that direct support staff have training on integrated employment. During 2022, Employment First Maine is sponsoring monthly employment learning webinar opportunities, sharing employment resources and tools to support HCBS participant with learning about work and exploring opportunities to pursue integrated employment.²⁹

Provider Tools and Samples

OADS and the EconSys SME time have worked collaboratively to respond to providers' requests for tools, sample policies, procedures, and examples of documentation that can assist them with achieving compliance. All tools and resources are presented on a monthly webinar and then posted on the HCBS Compliance Portal training and resources page. Resources include a "Provider Guide to Putting the Home and Community-Based Settings Rule into Practice," sample lease agreement, guidance tools on submitting evidence of remediation, sample policies on transportation, independence, privacy, security, integrated employment, behavior support and personal financial resources. Providers also received tools to educate HCBS participants on their rights under the Federal HCBS Rule, including an HCBS Rights Poster and HCBS Rack Card

²⁶ 42 C.F.R. § 441.301(c)(4)(ii).

²⁷ Angela Amado, PhD, formerly with the Institute on Community Integration

²⁸ Genni Sasnett, Independent Human Services Consultant specializing in community-based supports

²⁹ See <https://employmentfirstmaine.org/> (accessed February 4, 2022).

which can also be found at this web link (<https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources>) under the Provider Resources tab.

Planned Investments of Enhanced Federal Medicaid Matching Funding to Support Systems Changes and Providers in Achieving Full HCBS Rule Compliance

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021³⁰ (ARP). Section 9817 of the ARP provides states with a one-time Federal Medical Assistance Percentage (FMAP) funds for certain Medicaid HCBS from April 1, 2021 through March 31, 2022 to improve HCBS under the Medicaid program. States must use these additional federal funds to supplement, not supplant, existing state funds spent for HCBS. States must also match the additional federal funds with state funds and utilize the funding to implement or support implementation of one or more activities to enhance, expand or strengthen their HCBS programs.³¹

In response to this significant opportunity, the DHHS Commissioner, the Office of Aging and Disability Services (OADS) and the Office of MaineCare Services (OMS) hosted virtual listening sessions with stakeholders to obtain comments and recommendations as to how the resources from this unprecedented opportunity should be allocated.

Given COVID-19, stakeholders' primary concern was the immediate need to address the HCBS workforce challenges – noting that the shortage of direct support workers is the most significant barrier to people receiving the services they need to live independently and thrive. Other recommendations included funding all HCBS waitlists and a range of recommendations related to improving the quality of HCBS waivers and supporting innovation as part of the overall focus on improving quality to thereby improve the health and quality of life of MaineCare participants.

To address these recommendations and further improve the HCBS system, DHHS developed a preliminary plan released to the public on June 9, 2021.³² Approximately 60% of the funds were earmarked to directly increase wages for the HCBS workforce through special recruitment and retention bonus payments. DHHS held a virtual information and listening session to gather input on June 15, 2021. The preliminary plan proposed to invest the increased FMAP funds under ARP in three areas: timely access to services, innovating service delivery, and improving quality and accountability. Taking account of stakeholder input and the requirement to obtain federal approval of its plan, the State prepared a formal plan and submitted it to CMS on July 9, 2021. The State received partial approval of its plan from CMS and subsequently revised the remaining

³⁰ Public Law 117-2.

³¹ <https://www.medicare.gov/federal-policy-guidance/downloads/smd21003.pdf> (accessed February 2, 2022).

³² <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20DHHS%20Preliminary%20HCBS%20FMAP%20Plan%20June%209%202021.pdf> (accessed February 2, 2022).

elements of the plan based on CMS feedback. The State released the updated version of the plan on November 15, 2021.³³

The updated plan includes funds to support the HCBS Settings Rule transition-to-compliance initiative. According to the plan:

“The goal of this (FMAP investment) is to improve HCBS settings that require remediation through Maine’s Settings Rule implementation process. Providers are currently receiving Settings Findings Reports for each waiver setting that has undergone a review for alignment with the new HCBS requirements. Providers are requesting support and assistance to make the necessary changes and embrace systemic reform.” (ME 204; Page 11)

This represents a substantial and targeted investment in supporting providers to bring their HCBS settings into full compliance by providing the additional support and assistance that providers are requesting. This includes a one-time payment option for providers to assist with their costs related to complying with the HCBS Settings Rule, based on the results of setting validation and approved remediation plans for these settings. The State clarified that it plans to allow providers to use the one-time payment to make capital improvements specifically needed to complete remediation. One example is adding locks to bedroom doors. While these capital investments would not be eligible for federal match funding, investments in other support and assistance that providers are requesting would be eligible for federal match.

Additionally, the updated plan includes funds to invest in “Innovation Pilots” to stimulate innovation in HCBS to increase opportunities for waiver participants to achieve greater independence and community participation, and to prevent the use of unnecessarily restrictive settings. According to the plan:

“Maine’s innovation pilots will enhance and expand HCBS services...after a pilot period. DHHS will issue one or more RFPs calling for HCBS innovations that **more deeply integrate people into their communities** (emphasis added) by enhancing or expanding:

- Access to independence-enhancing technologies such as remote support.
- A range of independence-enhancing living options.
- Peer support models.
- Transitions across the lifespan; and
- New options close to home so individuals in out-of-state placements can return to Maine.

³³ State of Maine Initial Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 available at: <https://www.medicaid.gov/media/file/me-updated-spending-plan.pdf> (accessed February 7, 2022).

During the pilot period, we will test the innovations as potential Medicaid HCBS services. Innovations found to be effective will become Medicaid HCBS services in the future, through the normal waiver and state plan amendment process.”
(ME 201; Page 10)

These investments also include implementing a provider learning collaborative to support the success of the pilots and, ultimately, broader adoption of effective strategies resulting from the pilots.

Overall, the State’s plan for using federal ARP funding to stabilize and improve HCBS includes a multitude of initiatives that either directly or indirectly support the State’s transition-to-compliance with the Federal HCBS Settings Rule. Investments in providers, the direct service workforce, and innovation are all investments that will enable providers to bring their settings into full compliance.

Ongoing Investments in Systems-Change Efforts around Person-Centered Planning and Conflict-Free Case Management

To support the state’s work of building stronger provider capacity in the area of integrated community-based service delivery and adherence to Federal HCBS Settings Rule standards, the state of Maine has also been engaged in advancing a number of systems-change efforts to assure consistent use of person-centered practices in service planning and case management processes. In the last two years, OADS has engaged with consultants to develop updated approaches to person-centered assessment and planning for all five HCBS waivers, consistent with the person-centered planning requirements in the Federal HCBS Settings Rule.³⁴

The Section 19 efforts have involved a gap analysis, Person-Centered Planning process flow, development of a Person-Centered Planning Conversation Guide Assessment and Plan, a Person-Centered Planning Manual (August, 2021), consultation and training with Service Coordination Agencies (SCAs) and Care Coordinators (training completed September 3, 2021), identification of quality measures for person-centered planning, and adoption of updated administrative rules³⁵ in May 2021 for the Section 19 Waiver, incorporating applicable requirements from the Federal HCBS Settings Rule. The new person-centered assessment and planning process was implemented January 1, 2022.

For Sections 18, 20, 21, and 29, DHHS completed development of a draft enhancement to Maine’s Person-Centered Planning Process: Instruction Guide to:

³⁴ 42 C.F.R. §§ 441.301(c)(1)-(3).

³⁵ <https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s019.docx> (accessed February 7, 2022).

- a. Integrate stakeholder input/feedback, including the HCBS Stakeholder Advisory Committee (June 2021).
- b. Broaden the assessment process to capture, in addition to needs, individual strengths and preferences learned through getting to know the participant.
- c. Address the Department of Health and Human Services' agreement with the Department of Justice to assure:
 - Services that participants receive are determined by their individual needs and preferences, and not by provider preference.
 - The person-centered planning process identifies the amount, frequency, and type of service necessary to ensure the participant receives adequate and appropriate services and supports in the most integrated setting appropriate to their needs.

DHHS also completed an Interim Person-Centered Plan in its Enterprise Information System (EIS) for the Sections 18, 20, 21 and 29 waivers, which was rolled out June 2022 to address the Department of Health and Human Services' agreement with the Department of Justice assuring:

- The individual's Person-Centered Plan is informed by an assessment of functional needs and preferences, not provider preference.
- The person-centered planning process identifies the amount, frequency, and type of service necessary to ensure the participant receives adequate and appropriate services and supports in the most integrated setting appropriate to their needs.
- Discontinuation of provider entry into the Person-Centered Plan, and instead the identification of a proposed provider Service Implementation Plan (SIP) based on the individuals' goals, needs, and preferences identified in the Person-Centered Plan.

DHHS rolled out a person-centered planning training series starting in April 2022 to support the roll out of the enhanced person-centered service plan which was implemented in June 2022 through the use of the Department's health management record Enterprise Information System (EIS). The training and guidance included an updated instruction guide for person-centered planning to ensure consistent guidance and direction for participants, families and providers to align with intent and standards of the Home and Community Based Settings (HCBS) Final Rule and Maine's "Global Rule" (MaineCare Benefits Manual, Chapter 1, Section 6). Person-centered service planning tools to include the instruction guide are available on the Office of Aging and Disability Services (OADS) website along with recorded trainings, PowerPoint presentations and a frequently asked questions document.³⁶ A dedicated email address was developed and

³⁶ See <https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism/person-centered-planning>

continues to be utilized to offer person-centric support and feedback on an ongoing basis to support practice implementation and mastery of the enhancements.

DHHS also implemented an ongoing assessment of training needs for assuring person-centered planning in the Sections 21 and 29 waivers is conducted consistent with the Federal HCBS Settings Rule standards for person-centered planning.³⁷ As noted previously, addressing identified needs has included:

- January 2021: DHHS conducted a 6-part virtual webinar series (totaling 10 hours) on the following topics:
 - Overview of HCBS Qualities and the HCBS Modifications process, including interface with 14-197 C.M.R. Chapter 5.
 - What is a non-disability specific setting? Offering authentic choice of setting for HCBS during the person-centered planning process, including at least one non-disability specific setting option.

The webinar series was tailored for:

- Case Managers: 2 webinars (2 hours each)
- Section 18/20/21/29 Providers: 2 webinars (2 hours each)
- Persons with intellectual disabilities or autism and their families, Guardians: 2 webinars (1 hour each)
- Spring 2022:
 - Hybrid approach to learning to include live webinars and access to online training resources to promote person-centered thinking and planning.

DHHS also recently published proposed updates to the Section 21 Waiver rules,³⁸ with the public comment period closing January 31, 2022. The proposed changes for this rule associated with the waiver serving individuals with intellectual disabilities and autism include implementing changes proposed in the five-year renewal of this waiver, which CMS approved on September 25, 2020. Changes include provisions that incorporate the requirements of the Federal HCBS Settings Rule for person-centered service planning (See § 21.04-2 – Person-Centered Service Planning Process).

Additionally, updating the DHHS case-management information systems has been an ongoing project to support high quality, person-centered assessment and planning practices. DHHS has

³⁷ 42 C.F.R. § 441.301(c)(1)

³⁸ MBM Ch. II, Sec. 21, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder proposed rules available at: <https://www.maine.gov/tools/whatsnew/attach.php?id=6342782&an=1> (accessed February 7, 2022).

included the acceleration of its efforts on this project in its proposed plan³⁹ for using the additional federal matching funding (FMAP) that the state is able to access as a result of the passage of the American Rescue Plan Act of 2021⁴⁰ (ARP). Over \$19 million is earmarked for comprehensive HCBS information systems modernization including:

- Adoption of a new case management system for children with disabilities;
- Extending a provider database to new HCBS provider types;
- Connecting Adult Protective Services data with HCBS data to better capture trends, opportunities and threats;
- Connecting residential providers to the state’s Health Information Exchange;
- Developing specifications and procuring a learning management system (LMS) to deliver training and track worker certifications and progress across MaineCare HCBS programs and provide the state with a direct communication vehicle with DSWs; and
- Purchasing and distributing tablets to support implementation of electronic visit verifications (EVV).

These coordinated initiatives are all designed to assure system-wide compliance with the Federal HCBS requirements for person-centered planning and high quality, empowering and truly person-centered experiences all for waiver participants.

New and Planned Changes to HCBS Waivers to Incentivize Stronger Focus on Individualized, Integrated Community-based Services

The state is also working on several strategies related to service definitions, reimbursement methodologies, and outcomes-based performance measurement to strengthen the system’s ability to serve more HCBS waiver participants in individualized integrated community-based services.

The pandemic has impacted the delivery of Community Support Services to MaineCare participants. Effective July 1, 2021, Maine sought to enhance opportunities for community integration by adding two new “Community Membership” setting options, under the umbrella of Community Supports in the Sections 20, 21 and 29 waivers, to support individualized needs and expand the use of Community Supports more broadly during the Public Health Emergency. The two new “Community Membership” setting options, “Community Only-Individual” and “Community-Only Group”, have reimbursement rates distinct from facility-based Community Supports. These changes relate to disaster relief to alleviate beneficiaries’ fears of returning to congregate settings and provide more options of service delivery to aid reintegration into the community with rate differentials to address the smaller ratios for community integration. OADS

³⁹ State of Maine Initial Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 available at: <https://www.medicaid.gov/media/file/me-updated-pending-plan.pdf> (accessed February 7, 2022).

⁴⁰ Public Law 117-2.

received approval from CMS to add these two integrated “Community Membership” setting options under the Appendix K, amended in November 2021. The first providers were approved in December 2021 and as of February 2022, nine providers have received approval and are now able to offer the individualized service.

Community Membership services occur only in community settings and not in a provider owned or controlled or a disability-specific setting. The end date for Community Membership within the Section 29 waiver is the end of the six-month period following the termination of the federal COVID-19 public health emergency, but it can be made permanent upon promulgation of the MaineCare Benefits Manual⁴¹ Ch II, Section 29 rule through the state's prescribed APA rulemaking process as outlined in the state’s approved Section 1915(c) waiver application. The end date for Community Membership within the Sections 20 and 21 waivers is the end of the six month period following the termination of the federal COVID-19 public health emergency; but it can be made permanent upon CMS approval of a separate Section 1915(c) waiver amendment including these specific changes, followed by promulgation of the applicable MaineCare Benefits Manual rule through the state's prescribed APA rulemaking process as outlined in the state’s approved Section 1915(c) waiver application.

Community Membership allows for a participant to make connections to their own community, find and discover places to join and belong and learn about employment and their skills and interest as they relate to work.

DHHS is increasing reimbursement rates for many Home and Community Based Services (HCBS) effective January 1, 2022, pursuant Maine Public Law 2021, Ch. 398, Part AAAA, *An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain provisions for the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2021, June 30, 2022, and June 30, 2023.*⁴² These increases reflect additional funding sought by DHHS to:

- Update the cost-of-living adjustments (COLA)
- Fund the labor components of rates to ensure they equal at least 125 percent of minimum wage.

These efforts collectively will help the state prepare for future systems transformation focused on improving person-centeredness, self-direction, individualization, inclusion, and quality.

⁴¹ <https://www.maine.gov/sos/cec/rules/10/ch101.htm> (accessed February 8, 2022).

⁴² See [Updates on Part AAAA Reimbursement and Section 9817 HCBS Bonus Payments \(govdelivery.com\)](https://www.govdelivery.com) (accessed February 8, 2022).

Aligning Maine State Policy with the Federal HCBS Rule: Summary Findings from State Systemic Assessment

Criteria and Process

This section focuses on the initial state systemic assessment process, which included a comprehensive review of existing state Medicaid policies, licensing and other regulations, manuals, statutes, and other relevant documentation. The review and its results were included in the Initial STP and are also included in this Final STP. Additional information describing progress to date on systemic remediation has also been added to this Final STP.

To assess compliance with the Federal HCBS Settings Rule, each new requirement was compared with existing policy language, as of January 2020, that was embedded within the waiver applications approved by CMS,⁴³ the relevant section of the MaineCare Benefits Manual, licensing regulations for assisted housing,⁴⁴ certain statutes, and other related policies and procedures.

Maine policy was found to be compliant with the Federal HCBS Settings Rule applicable to settings when it captured all key elements of the Federal HCBS Settings Rule, or when the specific requirements of the rule were not applicable to a particular waiver-specific policy. For example, when a waiver program does not provide services in a provider owned or controlled residential setting, standards required specifically of provider owned or controlled residential settings were determined to be inapplicable.

In some cases, Maine policy did not address all the specific requirements of the Federal HCBS Settings Rule or was in conflict with the Rule. In addition, DHHS was also aware of certain situations where Maine policy might be substantially in compliance, but waiver programs do not currently have processes in place to adequately ensure that providers are in compliance with the stated policy. Table 4 describes each level of compliance by which existing state standards were evaluated.

⁴³ Medicaid waiver documents for all states may be accessed through CMS' website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html.

⁴⁴ All Maine Department of Health and Human Services rules may be accessed at: <http://www.maine.gov/sos/cec/rules/10/chaps10.htm>.

Table 4. Criteria for Classifying Compliance Status of State Standards (Statutes, Regulations, Policies & Processes)

Compliance Status	Criteria
<p>Fully Compliant:</p> <p>No change required</p>	<ul style="list-style-type: none"> • Current state policy captures the specific component of the Federal HCBS Rule under review and is consistent with the requirement, OR • The specific HCBS requirement does not apply to this waiver program (e.g., the program does not provide services in a provider owned or controlled residential setting)
<p>Partially Compliant:</p> <p>Some changes required</p>	<ul style="list-style-type: none"> • Current state policy captures some of the key element(s) of the Federal HCBS Rule is consistent with the requirement; BUT • There are some elements of the Federal HCBS Rule that are omitted in the state policy or there are places in existing state standards that are inconsistent with specific elements of the Federal HCBS Rule.
<p>Silent:</p> <p>Gap must be addressed in state statute, regulations, policy guidance and/or other standards</p>	<ul style="list-style-type: none"> • Current state policy omits a requirement under the Federal HCBS Rule and must be amended to address this gap/omission as silence does not equal compliance; AND
<p>Non-Compliant:</p> <p>Changes required in state statute, regulations, policy guidance and/or other standards</p>	<ul style="list-style-type: none"> • Current state policy is inconsistent with and counters a specific requirement(s) under the Federal HCBS Rule.

Trends in General Findings

At a general level, all five waiver systemic assessments contained five trends of import:

1) While support for community inclusion is referenced generally in the language of several policies across waiver programs, the state’s policies lacked definitions for several important terms outlined in the Federal HCBS Settings Rule standards, including but not limited to the following:

- Community Inclusion
- Competitive Integrated Employment
- Personal Resources
- Informed Choice
- Informed Consent

2) The definition used for Case Management did not necessarily reflect the importance of person-centered planning and the requirement that all participants have a person-centered plan/person-centered service plan (PCP/PCSP) that describes the participant’s needs, desires,

and preference with respect to where they live and spend their time, what covered services they want to receive, and who they want providing such services.

3) Current policies did not outline the process and appropriate documentation required in the PCP/PCSP with respect to any individualized HCBS modifications of settings standards specific to provider owned or controlled residential settings.

4) Few if any of the existing policies clearly stated that institutional settings were prohibited from receiving funding to provide MaineCare HCBS.

5) While many policies referenced general aspects of both the general and provider owned or controlled residential settings standards, often there was language attached to these references that limited or omitted the protections afforded to members.

This is a representative but not exhaustive list of some of the trends in findings the state team observed in its thorough review of the existing standards across all five waiver programs.

Specific Findings by Waiver

Due to each waiver having a distinct focus, whether it be on population, services, and/or service model design, it is important to summarize the key findings of each of the systemic assessments across the five waivers. The following section provides a brief synopsis of each waiver program and any unique findings from the systemic assessment for each waiver.

- **Section 18 [Home and Community-Based Services for Adults with Brain Injury (ME 1082)]**, the Section 1915(c) waiver authorizing the HCBS program for adults with brain injury under Section 18 was approved (May 6, 2014) after the effective date of the Federal HCBS Settings Rule. Before approving this waiver, CMS determined its policies to already be in compliance with the new HCBS rule. However, upon review of the state's standards for the Section 18 waiver, it was determined that several areas related to definitions of key terms and areas of partial compliance or silence necessitates a number of technical (and some substantive) changes. The policies reviewed include:
 - [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\) Chapter II, Section 18](#)
 - [Statute - Title 22, Maine Revised Statutes, chapter 715-A: Assistance for Survivors of Acquired Brain Injury](#)
 - [Licensing – 10-144 C.M.R. Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs](#)
- **Section 19 [Home and Community Benefits for the Elderly and for Adults with Disabilities (ME 0276)]**, covered HCBS are all delivered in a participant's individual private home or on an individualized basis out in a typical community setting. As such, these settings are presumed fully compliant with the rule by the state. However, there were still policies governing the Section 19 waiver program that will be modified to

reinforce adherence to the general requirements under the Federal HCBS Settings Rule. Through its efforts to strengthen person-centered planning across programs, DHHS will explore other program enhancements to ensure that individuals living at home have access to the community to the same extent as individuals not receiving HCBS.⁴⁵ The policies reviewed include:

- [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\), Chapter II, Section 19](#)
- [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\), Chapter I, Section 1](#)
- [Rule - 14-197 C.M.R. ch. 12: Reportable Events System](#)
- [Statute - Title 22, Maine Revised Statutes, Section 7317, In-home and community support services; nursing facility services](#)
- [Statute - Title 22, Maine Revised Statutes, Section 1812-J, Unlicensed assistive persons](#)
- [Statute - Title 22, Maine Revised Statutes, – Section 3174-I, Medicaid eligibility determinations for applicants to nursing homes](#)
- [Statute - Title 22, Maine Revised Statutes, – Section 5606, Violations](#)
- **Section 20 [Home and Community Services for Adults with Other Related Conditions (ME 0995)]** was approved by CMS on May 1, 2013. Since CMS was already applying most of the HCBS standards to new waivers at that time, the approved waiver document for Section 20 does include several of the Federal HCBS requirements. However, similar to Section 18, a deeper review of the policies associated with this waiver did reveal some key issues and areas of silence or partial compliance that need to be addressed, particularly with respect to ensuring that the requirements for qualified providers under the waiver clearly outlines the settings requirements that all providers must adhere to in every setting for which they are providing MaineCare HCBS. The policies that were reviewed for the Section 20 waiver include:
 - [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\), Chapters II & III, Section 20](#)
 - [Licensing – 10-144 C.M.R. Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs](#)

⁴⁵ According to written guidance from CMS, “[t]he regulations allow states to presume that the enrollee’s private home or the relative’s home in which the enrollee resides meets the requirements of HCB settings.” CMS also noted that “[w]hile a private home may afford the individual a home-like setting, the person-centered plan and provision of appropriate services that support access to the greater community are critical components to ensure community integration, especially for individuals with limited social skills.” Centers for Medicare & Medicaid Services, *HCBS Final Regulations 42 CFR Part 441: Questions and Answers Regarding Home and Community-Based Settings* (undated), accessed on February 27, 2015 at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/q-and-a-hcb-settings.pdf>.

- Section 21 [Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder (ME 0159)] is the waiver providing a comprehensive array of home and community-based services, including in-home supports, to individuals with an intellectual disability or autism. The policies reviewed for this waiver include:
 - [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\), Chapter II, Section 21](#)
 - [Rule - 14-197 C.M.R. ch. 5 Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine](#)
 - [Rule - 14-197 C.M.R. ch. 8: Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism](#)
 - [Rule: 14-197 C.M.R. ch. 12: Reportable Events System](#)
 - [Statute - Title 34-B, Maine Revised Statutes, Section 1218, Services to persons who are deaf or hard-of-hearings](#)
 - [Statute - Title 34-B, Maine Revised Statutes, Chapter 5, Intellectual Disabilities and Autism](#)
- **Section 29 [Support Services for Adults with Intellectual Disabilities or Autistic Disorder (ME 0467)]** provides community-based supports and in-home waiver to individuals with intellectual disability or autism. Shared Living residential settings as well as settings in which Work Supports and Community Supports are provided must be in full compliance with the appropriate federal and state HCBS requirements specific to each category of setting. The policies reviewed as part of the state’s systemic assessment include:
 - [Rule - MaineCare Benefits Manual \(10-144 C.M.R. ch. 101\), Chapter II, Section 29](#)
 - Rule - 14-197 C.M.R. ch. 5, Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine
 - Rule - 14-197 C.M.R. ch. 8, Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism
 - Rule: 14-197 C.M.R. ch. 12, Reportable Events System
 - Statute - Title 34-B, Maine Revised Statutes, Section 1218, Services to persons who are deaf or hard-of-hearing
 - Statute – Title 34-B, Maine Revised Statutes, Chapter 5, Intellectual Disabilities and Autism

The findings of the systemic assessments for each HCBS waiver program can be reviewed in Appendix V.

Timeline of Proposed Remediation of State Standards

Assuring compliance across all categories of settings in all waiver programs requires a concerted effort by the state to address all areas of partial compliance, silence, or non-compliance in existing state standards. After receiving initial feedback from stakeholders, consultants, and internal state programmatic experts, DHHS decided the most effective systemic remediation vehicle is a holistic approach that will consolidate the systemic findings in such a way as to assure continuity and consistency in language and expectations with respect to adherence to the Federal HCBS requirements across all of MaineCare’s HCBS programs.

In the Initial STP, DHHS proposed a strategy that was to include three key components:

- A new, separate section in Chapter I of the MaineCare Benefits Manual designed specifically for and about the provision of home and community-based waiver services and the expectations of settings providing HCBS under one or more of the MaineCare HCBS waiver programs (Target date for adoption: 12/31/20);
- Submission of a legislative proposal to the state legislature that provides a global bill outlining the specific state and Federal HCBS requirements expected of various categories of providers and settings moving forward (Target date for legislative action: spring, 2021); and
- Specific modifications to any state standards where there was a clear issue of non-compliance that would need to be remedied will still be addressed within the body of the state standard in question. However, there were very few areas where any state standard was deemed non-compliant (as opposed to partially compliant).

Update on Strategy and Timeline for Proposed Remediation of State Standards:

The global HCBS regulation and legislation were intended to address the areas of silence or partial compliance within the corresponding Sections of MaineCare rule. After extensive discussions between DHHS and the Office of the Attorney General, it was determined that a new “Global HCBS Waiver Person-Centered Planning and Settings Rule” (Global HCBS Waiver Rule), accomplished through the creation of a new, separate section in Chapter I of the MaineCare Benefits Manual, would be both sufficient and the most effective systemic remediation vehicle to assure a holistic approach that consolidated the systemic findings in such a way as to assure continuity and consistency in language and expectations with respect to adherence to the Federal HCBS requirements across all of MaineCare’s HCBS programs.

While determining there was not a need for companion legislation and statutory changes, the State maintained its commitment to including language in the MBM that clearly states the new section in Chapter I of the MBM (the Global HCBS Waiver Rule) will have the effect of superseding any existing, conflicting regulations in the MBM as they relate to requirements of providers of MaineCare HCBS. Further, the Global HCBS Waiver Rule allows for an open,

transparent, and consistent vehicle for members of the public and stakeholders to refer to in understanding what the expectations are of specific categories of HCBS settings, as well as the rights of waiver participants.

Within each of the waiver rules, the licensing rule, and any related waiver-specific policies, the state also remains committed to modifications to any existing language where there was a clear issue of non-compliance with the Federal HCBS Settings Rule that should be remedied to ensure consistency across all state rules and policies.

Development and Adoption of the Global HCBS Waiver Person-Centered Planning and Settings Rule

Work on the development of the Global HCBS Rule began in May 2020 and involved DHHS (OADS and OMS) and the Office of the Attorney General (OAG).

The draft Global HCBS Waiver Rule⁴⁶ was posted for public comment on August 18, 2021.

This global rule implements the federal requirements for all of Maine’s Section 1915(c) HCBS waiver programs as set forth in 42 C.F.R. § 441.301(c) and includes requirements for person-centered service planning and for settings in which HCBS are provided, including requirements for provider owned or controlled residential settings. The rule includes the following specific language:

“In the event of conflict between the requirements of this proposed rule and any rule listed above, the terms of the proposed rule will supersede and shall apply.” (MBM Ch. I, Sec. 6, § 6.01)

By including this language, the Global HCBS Rule implements the necessary additional requirements and/or changes to the five HCBS waiver programs under all of the following sections of the MaineCare Benefits Manual (10-144 C.M.R. ch. 101), Chapter II:

Section 18: Home and Community-Based Services for Adults with Brain Injury.

Section 19: Home and Community Benefits for the Elderly and Adults with Disabilities.

Section 20: Home and Community-Based Services for Adults with Other Related Conditions.

Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder; and

Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

⁴⁶ <https://www.maine.gov/tools/whatsnew/attach.php?id=5332456&an=1> (accessed February 2, 2022).

The Global HCBS Waiver Rule further clarifies that the participant leads the person-centered planning process and that the process should reflect the participant’s cultural considerations and provide necessary information to allow the participant to make informed choices and decisions.

As noted earlier in this Final STP, based on stakeholder feedback, the Global HCBS Waiver Rule also contains a provision related to certain disability specific settings (Section 18 Work Ordered Club House Services; Section 20 Community Support Service and Work Support Services; Section 21 Community Support Services and Work Support-Group Services; Section 29 Community Support Services and Work Support-Group Services). The Global HCBS Waiver Rule leaves open DHHS’s ability to amend Sec. 18, Sec. 20, Sec. 21 and/or Sec. 29 regulations through rulemaking to impose additional requirements. This changes the State’s original intent regarding these settings, which were classified as provider owned or controlled non-residential settings in the initial STP. These settings are now reclassified as disability-specific non-residential settings. The State may propose these additional requirements for disability-specific settings by setting them forth in individual program rules.

In addition, the rule re-states requirements elsewhere in the MBM that HCBS providers must be enrolled with OMS, have and comply with their provider agreement, and satisfy provider qualification requirements set forth in the applicable program rule. Finally, the Global HCBS Waiver Rule states that OADS has authority to enforce the rule, in addition to other enforcement provisions available under the MBM.

The state held a public hearing on the Global HCBS Rule on September 28, 2021, with a total of 140 individuals in attendance. The comment period closed on October 8, 2021. There were a total of 51 distinct commenters (including 38 written comments & 31 oral comments). Several individuals who commented orally also provided written comments). Commenters were stakeholders including the following: providers; parents/family; members receiving HCBS; advocates; attorneys from non-state organizations including Disability Rights Maine. Oral and written comments when summarized yielded 370 total comments. A summary of comments and state responses are posted here: <http://www.maine.gov/dhhs/oms/rules/index.shtml>.

Changes Made to Draft Global HCBS Waiver Rule in Response to Public Comment

The following substantive changes were made to the draft Global HCBS Waiver Rule based on public comments received:

1. Extended the effective date of the requirements in Subsection 6.04(A) and Subsection 6.04(B) of the proposed rule that apply to those HCBS settings that were approved as HCBS waiver settings before March 17, 2014, to September 30, 2022.
2. Revised the second sentence of Subsection 6.03(A) of the proposed Global HCBS Waiver Rule as follows: “The participant’s representative should have a participatory role, as needed and as defined by the participant (unless state law confers decision-

making authority on a legal representative)” to clarify the original phrase “as defined by the member.”

3. Changed Subsection 6.03(A)(4) and Subsection 6.03(B)(7) of the rule to replace “are limited English proficient” in that section with the statement below: “be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited proficiency in English, consistent with 42 C.F.R. [§ 435.905\(b\)](#).”.

Adoption of the Final Global HCBS Waiver Rule

The Department adopted the final Global HCBS Waiver Person-Centered Planning and Settings Rule with an effective date of January 19, 2022.⁴⁷ Despite the impact of COVID-19, this was accomplished just over one year after the target deadline of December 31, 2020, included in the initial STP.

Update on Other Remediation Needed to Address Systemic Assessment

The adoption of the Global HCBS Waiver Rule addressed much of the systemic remediation necessary. Additional systemic remediation, which requires changes beyond the adoption of the Global HCBS Waiver Rule, continues to be addressed by the State. This includes:

- Sections 18, 19, 20, 21 and 29 waiver changes and MBM waiver rule changes: (1) to ensure no conflict with the Global HCBS Waiver Person-Centered Planning and Settings Rule; (2) to address ongoing monitoring including privately owned/leased homes and individualized integrated community settings used for provision of HCBS; and finally, (3) for Sections 18, 20, 21, and 29, to address requirements for disability-specific non-residential settings.
 - Section 18 Update: MBM rule changes are anticipated to be adopted by late 2022 or early 2023.
 - Section 19 Update: MBM rule changes⁴⁸ were adopted May 2, 2021, which included person-centered planning requirements and a requirement that “All professional and other qualified staff must be trained upon hire, prior to the provision of services to a participant, and annually thereafter, regarding HCBS requirements” (§ 19.08-8). In response to the systemic assessment findings, the new person-centered assessment and planning process adopted January 1, 2022, includes domains that address community integration and integrated employment. Section 19 rules do not yet address ongoing monitoring that is required for privately owned/leased homes and individualized integrated community settings

⁴⁷ <https://www.maine.gov/sos/cec/rules/10/144/ch101/c1s006.docx> (accessed February 2, 2022).

⁴⁸ <https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s019.docx> (accessed February 7, 2022).

where the provision of HCBS occurs, to ensure each participant's experience is consistent with Federal HCBS Settings Rule general standards. However, the state intends, beginning in March of 2023, to conduct an annual Individual Experience Assessment (IEA) interview with all Section 19 participants. This will not be done as part of the PCP process but instead is planned to be a stand-alone process that will be done telephonically. Results would be available in real time for OADS managers to review. There would also be an ability for OADS managers to flag areas that need further review/follow up with Care Coordinators to correct situations where participants' experiences are not fully consistent with HCBS standards.

Additional MBM rule changes necessary will be incorporated into rulemaking planned for 2022 with adoption by early 2023.

- Section 20 Update: MBM rule changes are anticipated to be adopted by late 2022 or early 2023.
- Section 21 Update: Waiver changes have been completed and approved by CMS. An updated MBM rule was proposed on August 10, 2021. A public comment period was held ending January 31, 2022. This amended rule was adopted on May 22, 2022. Any additional MBM rule changes that may be needed to fully address requirements for disability-specific non-residential settings and to support ongoing monitoring are anticipated to be adopted as part of rulemaking after the next federal renewal of this waiver (June 30, 2025).
- Section 29 Update: MBM rule changes to be completed by December 31, 2022.
- [Licensing – 10-144 C.M.R. Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs.](#) The state is implementing a waiver process where licensing requirements are in conflict with HCBS settings standards. Providers will be able to request a waiver of the licensing requirement(s) that is in direct conflict with one or more HCBS setting standards in order to ensure full compliance with the HCBS setting standard(s) can be achieved. Future rulemaking will adopt changes to licensing regulations consistent with HCBS settings standards.
- [Rule - 14-197 C.M.R. Chapter 5: Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine.](#) The drafting process to update Chapter 5 has not been started; however, the State plans to incorporate all the areas identified in the systematic assessment into the drafting. The drafting of this rule is on hold until the University of New Hampshire (UNH) Institute on Disability/UCED completes a review of this rule as part of their systems evaluation of Maine's community system of care in addressing the needs of individuals with intellectual and developmental disabilities with co-occurring mental health conditions. UNH plans to complete this analysis by September 2022. Drafting will

commence with priority status to ensure rule changes are adopted by the March 2023 deadline.

- [Rule: 14-197 C.M.R. Chapter 12: Reportable Events System](#). The systemic assessment identified the need to ensure emergency restraints must be reported, consistent with the Federal HCBS Settings Rule requirement assuring participants experience freedom from restraint. The updated rule draft has been through the first review by the OAG. The rule is expected to be published for public comment by fall 2022 and adopted by spring 2023.

Setting Assessment, Validation and Remediation Processes

Overview of Maine’s HCBS Setting Categories

Services provided under Maine’s HCBS waiver programs are provided in a variety of settings. All residential and non-residential settings providing MaineCare HCBS are subject to assessment validation and remediation, except for [settings that can be presumed compliant](#) during the state’s transition-to-compliance period.

Types of Residential Settings

Table 5 provides an overview of the categories used for classifying residential settings utilized in each of the state’s waivers, including whether they are considered provider owned or controlled.

Waiver services provided in the participant’s own home (a home the participant owns or leases from a landlord other than a provider of HCBS services, or a home owned by an unpaid natural caregiver where the participant resides) are assumed to be in compliance with the Global HCBS Waiver Rule. One of Maine’s waiver programs (Section 19) currently provides HCBS only in the participant’s privately owned or leased home. These settings are subject to ongoing monitoring activities to ensure HCBS participants have an ongoing experience consistent with the rule requirements. More information on ongoing monitoring strategies can be found [in section titled Phase 5](#).

Table 5. Type of Residential Settings by MaineCare HCBS Waiver Program

Type of Setting	Section 18 Brain Injury	Section 19 Elder/Adult	Section 20 Other Related Conditions	Section 21 Adults ID/Autism HCBS	Section 29 Adults ID/Autism Support
Presumed Compliant*					
• Own Home or Apartment*	√	√	√	√	√
Not Provider Owned or Controlled					
• Shared Living-Related Caregiver	-	-	-	√	√
Provider Owned or Controlled					
• Group Homes	√	-	√	√	-
• Family-Centered Support Homes	-	-	-	√	-
• Shared Living-Unrelated Caregiver	-	-	-	√	√

*Not subject to assessment, validation and remediation during the state’s transition-to-compliance period.

Four of Maine's five waivers (Section 18, Section 20, Section 21, Section 29) provide services in residential settings that are subject to assessment, validation and remediation (if required) during the transition period. These include Shared Living-Related Caregiver settings (Section 21, Section 29) that are not considered to be provider owned or controlled but must meet the general rule requirements that apply to all settings. These settings also include various provider owned or controlled residential settings, including group homes, shared living arrangements involving unrelated caregivers, and family-centered homes. Each type of these residential settings is described on the following pages.

Group Homes

A group home is a provider owned or controlled residential service location for which the provider routinely employs direct support staff to provide direct support services on the premises to the degree the individual requires (often 24/7 supports), as well as assisting the individual to engage in the community. A group home may serve up to six individuals.

The group home model is available only to persons participating under three waivers: Section 18 (adults with brain injury), Section 20 (adults with other related conditions), or Section 21 (adults with an intellectual disability or autism). These settings may or may not be licensed.⁴⁹ Licensing is voluntary for group home settings with two or fewer beds. Based on DHHS's analysis in 2/8/2020, 51 group homes were providing services under the Section 18 waiver, 11 group homes were serving individuals receiving services under the Section 20 waiver, and 868 group homes were serving individuals served under the Section 21 waiver.

Shared Living Arrangements

A Shared Living Arrangement is a residential model in which services are provided to a participant by a person who meets all the requirements of a Direct Support Professional, with whom that participant shares a home. The home may belong to the provider or the participant. Shared Living is similar to adult foster care except that there is an expectation of a more cooperative sharing of space and supports between adults. Only one participant may receive services in a Shared Living arrangement unless a relationship between two participants pre-exists the Shared Living arrangement and the Shared Living arrangement is approved by DHHS. The participant becomes part of Shared Living provider's life, family, home and community. Shared Living Arrangements where the participant shares a home with an unrelated caregiver are considered provider owned or controlled while Shared Living settings where a related family

⁴⁹ Maine Department of Health and Human Services rule, Title 10-144, Code of Maine Rules, Chapter 113, *Regulations Governing the Licensing and Functioning of Assisted Housing Programs*. Accessed November 6, 2014 at <http://www.maine.gov/sos/cec/rules/10/chaps10.htm>.

member provides support are not considered to be provided-owned or controlled residential settings. Shared Living settings are not licensed.

As of 2/8/2020, there were 897 settings in which Shared Living services are provided under the Section 21 waiver, and 490 settings under the Section 29 waiver.

Family-Centered Support

Family-Centered Support is a residential model designed to provide enhanced home support to a member in a family environment, with the family and the participant sharing a home that is not owned by the participant or participant’s family. Any family-centered support homes that serve three or more participants must be licensed and can include up to six (6) participants living together. This model of residential setting is currently being phased out, and thus no new Family-Centered Support programs have been approved since 2007.

This model is available only to participants participating under the Section 21 waiver. As of 2/8/2020, DHHS determined that 52 Family-Centered Support settings exist under Section 21 with individuals receive services in these settings.

Table 6. Number of Residential Settings across Maine’s HCBS Waiver Authorities, by Setting Category (as of 2/8/2020)

Setting Type	Section 18	Section 19	Section 20	Section 21	Section 29	Total
Group Home	51		11	868		930
Shared Living*				897	490	1,387
Family-Centered Support Homes				52		52
Total	51		11	1,817	490	2,369

*Some settings for Section 21 may also serve Section 29 participants which results in counting the setting twice. The total unduplicated count for all residential settings is 2,087.

Types of Non-Residential Settings

Four of Maine’s five waivers (Section 18, Section 20, Section 21, Section 29) provide non-residential services on an individualized basis in integrated community settings and workplaces. Because these services are provided in typical community settings that are not provider owned or controlled, and the services are provided on an individual basis, these settings are assumed to be compliant with the Global HCBS Waiver Rule. While these settings are therefore not subject to assessment, validation and remediation during the transition period, these settings must be included in ongoing monitoring activities to ensure members have an ongoing experience consistent with the Global HCBS Waiver Rule.

Three of Maine’s waivers also provide services in non-residential, disability-specific settings targeting specific disability groups. This includes center-based Community Support services

(Sections 21 & 29), Work Support provided in a group model, i.e., mobile work crews or enclaves (Sections 21 & 29), and Club House settings (Section 18).

Table 7. Type of Non-Residential Settings Where Services May Be Provided by Waiver Program

Type of Non-Residential Setting	Section 18 Brain Injury	Section 19 Elder/Adult	Section 20 Other Related Conditions	Section 21 Adults ID/Autism HCBS	Section 21 Adults ID/Autism Support
Individualized, Typical Community (Non-Disability Specific) *					
Integrated Individualized Community Support Settings	√	-	√	√	√
Integrated Work Support-Individual Settings	√	-	√	√	√
Disability-Specific Settings					
Center-based Community Supports	-	-	-	√	√
Work Support-Group Settings	-	-	-	√	√
Club House Supports	√	-	-	-	-

*Not subject to assessment, validation, and remediation during the state’s transition-to-compliance period.

Center-Based Community Support

As of 2/8/2020, there were 166 center-based settings that provide Community Support. Community Support is provided by a Direct Support Professional (DSP) employed by an OADS approved provider, in order to increase or maintain a participant’s ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

Community Support is intended to be flexible, responsive, and provided to participants as defined by the participant’s choice and needs, including access to non-disability specific settings as documented in the participant’s Personal Plan. Community Support must have a community component (use of non-disability-specific setting or settings) that is individualized and based upon informed choice of each participant. Services are provided to develop positive social roles in the community and participation in activities could include volunteering, learning new skills, accessing community events and businesses, increasing health and wellness, developing and enhancing relationships with others, and citizenship skills. The service will be based on a process that spends time exploring and discovering a participant’s interests, finds places in a community where participants can become involved, and leads to the development of new natural supports, relationships, and connections. The activities shall support the acquisition of new skills as well as support for self-determination, the development of relationships, community integration,

employment exploration and community contribution. Community Support can be provided via a one participant to one DSP ratio (1:1) but shall not exceed a three participant to one DSP ratio (3:1) in any setting.⁵⁰

Work Support – Group

As of 2/8/2020, Maine had thirteen (13) settings in which Work Support was provided to a group of two or more waiver participants. Such settings provide Work Supports using enclave, mobile work crew, or agency-owned business models, which provide opportunities for participants to gain skills for integrated employment through work experience in group model. These groups range in size from two to six.

Work Ordered Day – Club House

The Work Ordered Day – Club House is designed to help participants build skills specific to a work environment. In addition, they have the added benefit of the social engagement with others and relearning the interpersonal skills required to succeed in a work setting. This is often a barrier for individuals with brain injury in their process of returning successfully to a work environment. Having a Club House model allows for the participants to relearn these skills in a safe and respectful environment. This is the evidence-based practice. The provider of the service focuses staff training on specific to the needs of the participant as it relates to their acquired brain injury. These services can be delivered in a variety of settings but are typically in a building in the community not adjacent to a facility or institution. Participants will have the freedom to come and go as they please as long as it fits their health and welfare needs. The buildings are in the community and the public has access to the building. The model helps staff understand each participant and deliver the appropriate supports to the participant. As of 2/8/2020, the Section 18 waiver had one (1) Club House provider.

Table 8. Number of Non-Residential Settings across Maine’s HCBS Waivers by Number, Category, and Waiver Authority*

Type of Setting	Section 18	Section 21	Section 29	Sections 21/29	Total
Center-Based Community Support		165	159		165
Work-Support Group				13	13
Club House Support	1				1

* As of 2/8/2020

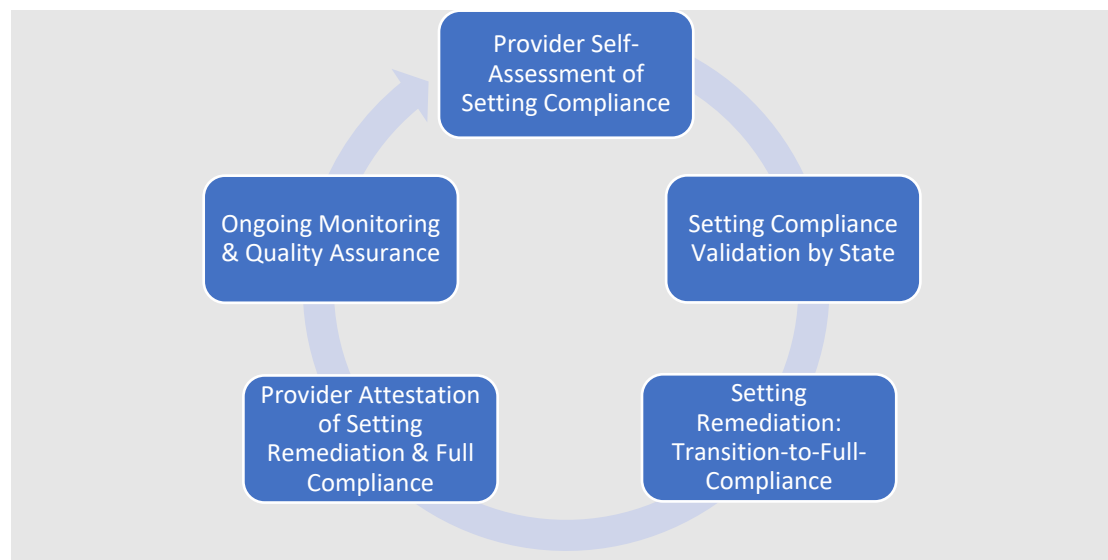
⁵⁰ During the COVID-19 Public Health Emergency, the state is permitting a DSP to participant ratio of up to 6:1 and use of a telehealth option; however, these provisions will not continue beyond the Public Health Emergency.

Overview of Maine’s Setting Compliance Process

As part of implementing the Federal HCBS Settings Rule standards, CMS requires states to ensure that all settings providing Medicaid-funded HCBS are fully compliant with the general settings standards, and that provider owned or controlled residential settings fully comply with the additional requirements set forth in the Federal HCBS Settings Rule for those particular settings. These settings requirements are made applicable to MaineCare waiver providers by the state’s Global HCBS Waiver Rule. For existing settings, full compliance must be achieved on timelines set forth in the Global HCBS Waiver Rule to ensure that, by March 17, 2023, no HCBS participant is receiving services in a setting that has not been confirmed by the state to have achieved full compliance, thus ensuring no loss of federal match funding for the state’s HCBS waiver programs.

To complete this work with fidelity, the state of Maine is applying a five-phase approach to helping settings meet all applicable settings standards: provider self-assessment of setting compliance; setting compliance validation by state; setting remediation & transition-to-full-compliance; provider attestation of completed remediation and full compliance; and ongoing monitoring & quality assurance.

Figure 2. Maine’s Five-Phase Approach to HCBS Settings Compliance



- Phase 1 – Provider Self-Assessment of Setting Compliance:** In Phase 1, Maine requested that all MaineCare HCBS providers conduct a preliminary assessment of setting compliance with the Federal HCBS settings standards across HCBS state authorities and all categories of settings that cannot be presumed compliant. The information obtained from this effort helped the state identify trends in areas of compliance, partial compliance and non-compliance across waivers and categories of settings with respect to specific setting standards. The information was also used to

inform the state about the types of ongoing training and technical assistance providers will need in order to remediate partial and non-compliance and improve the overall quality of their service delivery models.

- **Phase 2 – Setting Compliance Validation by State:** During Phase 2, every setting within MaineCare’s system that could not automatically be presumed to be compliant with applicable settings standards was independently validated to confirm the setting’s level of compliance with applicable settings standards. By the deadlines set forth in Maine’s Global HCBS Waiver Rule, every setting must comply fully with all applicable Global HCBS Waiver Rule requirements. Validation must be completed via activities separate from and independent of the provider self-assessment. Many states have applied more than one strategy to validate a setting’s adherence to settings standards, particularly if the State did not have sufficient resources to conduct onsite validation for all HCBS settings. In Maine, settings were validated either by an onsite validation visit, or review of Individual Experience Assessments (IEAs) completed by a minimum percentage of HCBS participants receiving services in the setting coupled with a desk review for all relevant setting requirements not otherwise susceptible to validation via IEAs. Compliance validation also included identification of settings that isolate HCBS participants from the broader community, including members of the broader community who do not receive HCBS. Isolating settings were informed they are subject to heightened scrutiny by CMS as described in [Overview of Heightened Scrutiny Process](#) section.
- **Phase 3 – Setting Remediation & Transition-to-Full-Compliance:** Phase 3 is on-going and consists of DHHS sharing its findings from the validation activities for each setting with the provider that operates the setting and working with the provider to develop a plan of action to remediate the setting, known as a “Transition-to-Compliance Plan” (TTCP), which outlines the specific remediation activities needed to bring the setting into full compliance with the Global HCBS Waiver Rule. A TTCP establish the provider’s plan to remediate its setting that is approved by the state and functions as a roadmap for the state to work with the provider to remediate any areas of non-compliance prior to the applicable deadline in the Global HCBS Waiver Rule.
- **Phase 4 – Provider Attestation of Setting Remediation & Full Compliance:** With respect to all settings for which the providers had been asked to develop a TTCP, providers are undertaking their proposed setting remediation outlined in their TTCP. Also during Phase 4, the state will engage with providers to support and confirm the completion of these remediation activities.
- **Phase 5 – Ongoing Monitoring & Quality Assurance:** Finally, once providers have implemented all proposed settings remediation to ensure settings are compliant with applicable requirements in the Global HCBS Waiver Rule, the state will continue to engage in ongoing monitoring of the settings, through a variety of methods including use

of its regional quality assurance teams, to assure the settings continue to adhere to these requirements. For a detailed explanation of the State’s plan, see [Ongoing Monitoring](#).

Defining Settings Subject to Assessment, Validation & Remediation

There are two key definitions that were followed as parameters for settings assessment, validation, and remediation: “individualized private homes and settings”, and “group settings” that were subject to assessment, validation, and remediation as necessary.

Individual Private Homes and Individualized Settings for Supports in the Community: If a participant lives in their own private home (a home the participant owns or leases from a landlord other than a provider of HCBS⁵¹, or the private home of a family member or other natural support that is not being paid to provide HCBS, CMS confirms that these settings may be considered by the state of Maine to be fully compliant with applicable settings standards, and thus did not have to undergo setting assessment, validation or remediation. However, any home that a participant resides in that does not fall into any of the above categories (e.g., provider owned or controlled residential settings and Shared Living settings owned by a paid caregiver, including a paid relative) was subject to the five-phased approach described above including setting assessment, validation, and remediation.

Additionally, participants receiving services to support them to seek and work in individualized supported employment (Work Support-Individual) or to engage in activities in the broader community on an individualized basis and outside of a disability-specific setting(s) may also be considered fully compliant with applicable settings standards. However, these settings must be included in the state’s ongoing monitoring processes, and providers will be responsible for addressing any gaps in compliance with one or more of the Global HCBS Waiver Rule standards that may be identified during these ongoing monitoring activities (see section [Phase 5](#).)

Group Settings: Any setting where two or more people are grouped together for the purposes of receiving MaineCare HCBS were asked to participate in the five-phase approach to setting compliance described above regardless of whether the setting is provider owned or controlled, disability-specific or community-based.

Phase 1: Provider Self-Assessment Process

Providers were asked to complete a comprehensive self-assessment in November 2019 for each setting they operate that provides MaineCare HCBS. The purpose of the self-assessment was to gauge where settings across the various waivers were at in terms of compliance with HCBS settings standards, from the perspective of the providers operating those settings. Any settings

⁵¹ A landlord that is considered an HCBS provider includes an entity that has a direct financial relationship with a provider of HCBS, an entity that requires use of a particular service provider as a condition of the lease, and a related family member that is paid to provide HCBS in a Shared Living arrangement.

for which providers did not complete the provider self-assessment were automatically included in the sample of settings to receive an onsite validation visit by the State’s trained contract team to establish the setting’s level of compliance.

OADS and DHHS’s contractor, Economic Systems (EconSys) collaborated to develop draft provider self-assessment tools for residential and non-residential settings. These tools were derived from CMS’s exploratory questions⁵² for residential and non-residential settings and other states’ provider self-assessment examples. Drafts were shared with the Stakeholder Advisory Committee for review and feedback, which was incorporated into the final versions of the self-assessments. OADS and EconSys then worked together to provide training for providers on the HCBS settings standards, the creation of the online HCBS Compliance Portal to facilitate the transition-to-compliance process, the purpose of the self-assessment and how to complete the self-assessment for their settings. EconSys established a Help Desk providers could contact for assistance at any time and this Help Desk will remain in place through at least the end of the transition period (March 2023).

Provider Self-Assessment Completion Rate

Of the 2,086 residential settings providing MaineCare HCBS that were asked to conduct settings self-assessment, 2,081 (or 99.8%) completed and submitted the self-assessment to DHHS via the online HCBS Compliance Portal. All of the 179 (or 100%) non-residential settings across the state’s HCBS waiver authorities also completed and submitted the self-assessment to DHHS via the online HCBS Compliance Portal. Table 9 provides a summary of the completion rate for setting self-assessments.

Table 9. Completion Rate of Provider HCBS Self-Assessments, Residential v. Non-Residential

Residential Settings	Non-Residential Settings
<ul style="list-style-type: none"> • Shared Living (Related Provider) • Shared Living (Unrelated Provider) • Group Homes (1-6 ppl) • Family-Centered Homes 	<ul style="list-style-type: none"> • Center-Based Community Support • Club House • Work Support-Group
Total Settings Required to Submit = 2,086	Total Settings = 179
Submitted Self-Assessments = 2,081	Submitted Self-Assessments = 179
Submission Rate = 99.8%	Submission Rate = 100%

Note: The State extended the deadline to accommodate late submissions from November 30 to December 13, 2019. Non-submission after December 13, 2019 resulted in the setting being placed on the list for onsite validation.

⁵² Exploratory questions for residential settings: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Exploratory-questions-re-settings-characteristics.pdf> (accessed February 2, 2022). Exploratory questions for non-residential settings: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf> (accessed February 2, 2022).

Initial Findings from Provider Self-Assessment Process

The provider self-assessments enabled DHHS to confirm that no settings it considers institutional were being used for HCBS provision. Tables 10 and 11 show the results of the first six self-assessment questions by setting category. These questions followed the Federal HCBS regulation and guidance, focusing on assessing whether a setting is institutional in nature. The first two questions addressed two types of settings that, under existing state of Maine policy, cannot be used for the provision of HCBS:

1. Prong 1: Is the setting adjacent to or under the same roof as a building that houses a publicly or privately-operated setting which provides inpatient institutional care: (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital)?
2. Prong 2: Is the setting located on the grounds of, or immediately adjacent to, a building that is a public institution which provides inpatient institutional care: (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital)?

As anticipated, providers reported none of their existing HCBS settings fell into these categories.

Questions 3-6 are questions mirroring CMS March 2019 guidance⁵³ on identifying settings that are Prong 3: settings that isolate HCBS waiver participants from the broader community.

3. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community, including the broader community of individuals not receiving Medicaid-funded HCBS?
4. Due to model used for service provision, do individuals have limited opportunities – as compared to individuals living in the same community that do not receive HCBS - for interaction in and with the broader community, including interactions with individuals not receiving Medicaid HCBS?
5. Does the setting restrict and/or limit individuals' choices to receive services provided by the setting outside of the setting or to engage in activities outside of the setting?
6. Is the setting physically located separate and apart from the broader local community?

Maine is a very rural state so it was anticipated that a high proportion of residential settings in particular would be physically located separate and apart from the broader local community (Q6) and this was borne out by the results of the provider self-assessments. As described in detail in this STP's section on [heightened scrutiny settings](#), being physically located separate and apart from the broader local community did not automatically result in a conclusion that a setting was

⁵³ See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf> (accessed February 8, 2002).

isolating. Other factors were part of the evaluation during the validation phase including, most importantly, whether Q3, Q4 and/or Q5 were answered affirmatively. As Table 10 and 11 illustrate, providers self-assessing their settings did not find most of their settings to affirmatively align with what is described in Q3 through Q5. However, a higher percentage of non-residential settings than residential settings answered these questions affirmatively which ultimately aligned with the results of setting validation. Similar to other states' experiences, independent validation also resulted in greater levels of noncompliance than provider's self-reported through the self-assessment process.

Table 10. Self-Reported Non-Compliance of Presumptively Institutional Setting Status (Residential)

Residential Setting Type	Q1	Q2	Q3	Q4	Q5	Q6	Total Number of Settings*
1-2 Person Group Home	0	0	0	14	5	37	468
3-5 Person Group Home	0	0	1	4	1	28	261
6-or More Person Group Home	0	0	0	1	0	9	36
Family-Centered Home	0	0	2	0	0	5	53
Shared Living - Related Family Member is Provider	0	0	3	6	2	180	648
Shared Living - Unrelated Provider	0	0	3	4	2	151	495
All Settings	0	0	9	29	10	410	1,961

*Not including 5 settings that failed to submit self-assessment and 120 settings that completed a self-assessment which were subsequently no longer being used for HCBS as of the date this analysis was compiled (2/8/2020).

Table 11. Self-Reported Non-Compliance of Presumptively Institutional Setting Status (Non-Residential)

Non-Residential Setting Type	Q1	Q2	Q3	Q4	Q5	Q6	Total Number of Settings*
Club House	0	0	0	0	0	0	1
Community Supports	0	0	4	10	4	9	165
Work Support-Group	0	0	0	0	0	3	13
All Settings	0	0	4	10	4	12	179

*Not including 1 setting that completed a self-assessment which were subsequently no longer being used for HCBS as of the date this analysis was compiled (2/8/2020).

Upon deeper review of the setting self-assessment responses from HCBS providers, the following trends were identified, suggesting areas where potential remediation and technical assistance might be needed across all categories of provider owned or controlled residential settings:

- Practical accessibility to the typical community (lack of sidewalks, walking paths, communal settings in walking distances or near setting's physical location)
- Lack of public transportation or support to access transportation options to get to activities based in typical community settings
- Lack of flexible services to facilitate or support competitive integrated employment
- Lack of control over personal resources (cash, spending money, banking, and information technology/internet devices)
- Lease agreement with protections afforded under the state's landlord-tenant law
- Private living spaces (i.e., their unit if they live alone or, if they live with others not part of their immediate self-defined family, their bedroom) lacking lockable entrance doors with only the person and appropriate staff having a key or code to open the door(s)
- Choice of staff providing services

These trends were identified based on self-assessment questions where over 40% of the total settings reported being non-compliant, and where each setting category included at least 20% of settings that reported being non-compliant.

Because Shared Living involving a related family member as provider is not considered provider owned or controlled, only the general HCBS settings standards apply to these settings. As such, these settings were evaluated separate from the above-mentioned trends analysis for provider owned or controlled settings. Based on a distinct review of the self-assessment responses for these Shared Living-related family member settings, there were concerns noted with noncompliance in the following areas:

- Individuals having privacy and autonomy with respect to phone/computer use and having visitors over
- Control over personal resources (cash, spending money, banking, and information technology/internet devices)
- Ability to seek employment in integrated settings
- Ability to engage in some community activities of interest with readily available public transportation or transportation via natural supports
- Ability to engage in community activities even if home is far from communal entities (sports events, movie theatres, shops, restaurants, local businesses, churches)

Areas of concern, similar to those for residential settings, were identified in reviewing the findings of provider self-assessments for non-residential settings. Additionally, it was noted that challenges in accessing public transportation, as well as lack of control over personal resources, and diversity in choice of community-based activities and options were common themes cited by providers operating non-residential service settings.

These are areas that have been and will continue to be prioritized for training purposes to assure that providers across the range of HCBS settings have the tools and support they need to remediate these and other areas of non-compliance prior to the applicable deadline in the Global HCBS Waiver Rule.

Appendix VI includes a chart that breaks out trend data, across setting categories, based on provider self-assessment responses indicating setting compliance rates with policies and practices that reflect the HCBS settings standards.

Over the course of the process, some of these existing settings that were asked to submit self-assessments stopped (or will stop prior to March 17, 2023) being used to provide HCBS to waiver participants. This has been relatively common for residential settings, particularly Shared Living settings, as providers that lease these settings relocate fairly frequently. This does not represent a loss of HCBS capacity; but rather the use of new and different settings that were not previously being used for HCBS. When this occurs, these ‘vacated’ settings were no longer included in the total pool of existing settings that were asked to go through validation and remediation during the transition-to-compliance period. As Tables 12 through 14 shows, there were 120 residential settings and 1 nonresidential setting, subject to self-assessment, that were no longer being used to serve HCBS participants when the validation phase began in February 2020.

Table 12: Breakdown of Existing Settings - One or More Clients Being Served

Setting Type	Residential	Non-Residential
1-2 Person Group Home	470	NA
3-5 Person Group Home	261	NA
6-or More Person Group Home	36	NA
Family-Centered Home	56	NA
Shared Living - Related Family Member is Provider	648	NA
Shared Living - Unrelated Provider	495	NA
Club House	NA	1
Community Supports	NA	165
Work Support-Group	NA	13
<i>Total Settings Subject to Self-Assessment Process</i>	<i>1,966</i>	<i>179</i>

Table 13: Breakdown of Existing Settings – No Client Served

Setting Type	Residential	Non-Residential
1-2 Person Group Home	60	NA
3-5 Person Group Home	11	NA
6-or More Person Group Home	1	NA
Family-Centered Home	1	NA
Shared Living - Related Family Member is Provider	17	NA
Shared Living - Unrelated Provider	30	NA
Club House	NA	0
Club House	NA	0
Community Supports	NA	1
Work Support-Group	NA	0
<i>Settings no longer serving at least one (1) HCBS participant</i>	<i>120</i>	<i>1</i>

Table 14: Breakdown of Existing Settings -One or More Clients Being Served or No Client Served

Setting Type	Residential	Non-Residential
1-2 Person Group Home	530	NA
3-5 Person Group Home	272	NA
6-or More Person Group Home	37	NA
Family-Centered Home	57	NA
Shared Living - Related Family Member is Provider	665	NA
Shared Living - Unrelated Provider	525	NA
Club House	NA	1
Community Supports	NA	166
Work Support-Group	NA	13
<i>Total Settings</i>	<i>2,086</i>	<i>180</i>

Phase 2: Validation Process

Maine used two primary methods, separate from the provider self-assessment, to validate individual settings for compliance with the HCBS settings standards. These methods were:

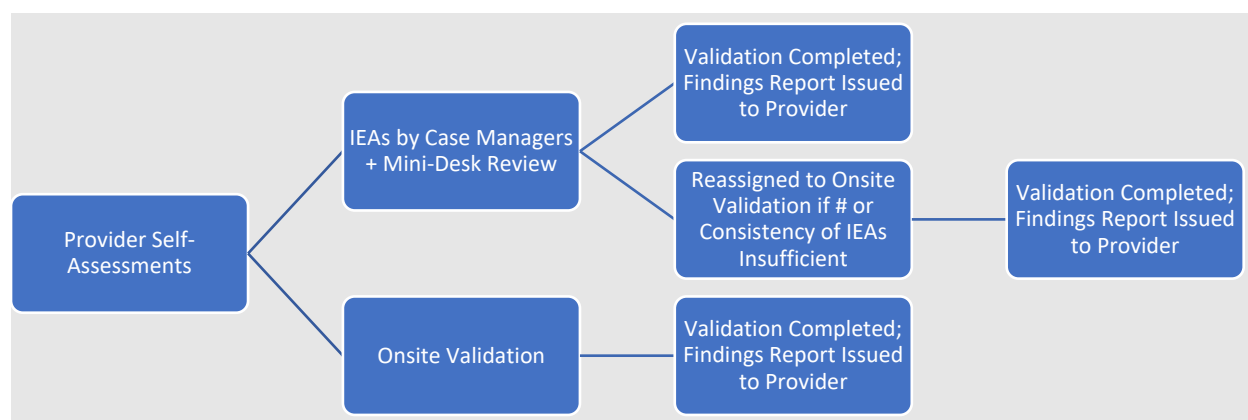
1. Onsite validation visits; or
2. A combination approach using Individual Experience Assessments (IEAs) completed by a minimum threshold percentage of HCBS participants receiving services in the setting and a desk review for all relevant setting requirements not otherwise able to be validated by the IEAs.

Due to limited budgetary resources and time constraints, it was not possible for DHHS to complete an onsite validation visit to every setting within the timeframe for setting validations to be completed, in order to leave sufficient time for providers to remediate any setting

noncompliance. Given this, DHHS determined that 645 settings would receive onsite visits: 466 (24%) of 1,967 residential settings and 179 (100%) of non-residential settings. The remaining settings were validated through the combination approach involving trained case managers conducting IEA interviews with waiver participants and the use of a desk review to cover setting requirements not otherwise able to be validated by the IEAs.

If any setting did not meet the minimum IEA completion threshold, it was reassigned to onsite validation. If IEAs for a setting did not result in a clear picture for validation (e.g., significant inconsistency in responses for a single setting), the setting was reassigned for onsite validation.

Figure 3. Outline of Maine’s Methodology for Completing Independent Validation of All HCBS Settings



Provider self-assessment responses were compared to the information from the above validation strategies. The findings based on the validation strategies determined whether the setting was in fact compliant or needed remediation. A findings report was issued for each setting when validation was completed which outlined what must be done to bring that setting into full compliance in time for the March 17, 2023 deadline.

On-Site Validation Visits

A total of 645 settings (or 30% of the 2,146 total settings that were validated) were selected to receive an on-site validation visit, as follows:

- 100% of all three categories of Non-Residential setting types (Community Support, Work Support-Group & Club House) received onsite validation;
- 24% of six categories of Residential setting types received onsite validation.
- 19% Group Homes (1-2 person);
- 37% Group Homes (3-5 person);
- 100% Group Homes (6+ person);

- 21% Family Centered Homes;
- 10% Shared Living-Related Family Member; and
- 34% Shared Living-Unrelated Provider.

Settings of each type that were selected for an onsite visit (see Table 16) were spread as evenly as possible across the state’s regions to assure proportional statewide representation. Random selection was completed in a way that ensured maximum number of distinct providers were included so every provider had a minimum of one setting selected for onsite validation.

Table 15. Breakdown of HCBS Residential Settings Receiving Onsite Validations, by Setting Type

Residential Setting Type	Onsite Visits-DRM	Total	% Onsite Visits-DRM
1-2 Person Group Home	89	470	19%
3-5 Person Group Home	96	261	37%
6-or More Person Group Home	36	36	100%
Family-Centered Home	11	56	20%
Shared Living - Related Family Member is Provider	63	648	10%
Shared Living - Unrelated Provider	171	495	34%
All Settings	466	1966	24%

The State contracted with EconSys and Disability Rights Maine (DRM) to conduct most of the on-site validation activities. Tables 17 and 18 shows the breakdown of on-site validations assigned to DRM, with 14 non-residential validations assigned to OADS staff. EconSys and DRM worked with the state to create the on-site validation assessment tools for residential and non-residential settings. These tools mirrored the content of the provider self-assessments. In other words, they measured the same elements measured in the provider self-assessments to ensure validation of provider self-assessment responses was possible. The onsite validation tools included additional “validator prompts” for each element to be measured, giving validators guidance on types of evidence to look for and questions to ask as part of making validation determinations. Onsite validations included: touring the setting; speaking to a sample of staff and waiver participants receiving services in the setting and reviewing the person-centered plans (PCPs) for these individuals, reviewing policies/procedures and other documentation of the setting’s service delivery; and observation of the setting’s location in relation to the broader community. To reduce the burden on providers, if a provider had multiple settings selected for on-site validation, only the first validation visit would include a request for and review of agency policies, etc.

Table 16. Breakdown of HCBS Non-Residential Settings Receiving Onsite Validations, by Setting Type

Non-Residential Setting Type	Onsite Visits-OADS	Onsite Visits-DRM	Total	% Onsite Visits
Community Support	-	165	165	100%
Work Support-Group	13	-	13	100%
Club House	1	-	1	100%
Grand Total	14	165	179	100%

Table 17. Validation Approach Used to Define Areas of Setting Noncompliance Included in Setting Findings Report

Provider Self-Assessment	Validator Assessment	Conclusion	Included in Findings Report
Compliant Response	Compliant Finding	Compliant	No
Compliant Response	Noncompliant Finding	Noncompliant	Yes
Noncompliant Response	Noncompliant Finding	Noncompliant	Yes
Noncompliant Response	Compliant Finding	Compliant	No

DRM recruited a team of seven validators. DRM and EconSys consultants worked together to design a comprehensive validator training for both DRM and OADS validators. The State reviewed and approved the training content. DRM conducted an intensive two-day, in-person validator training, and an EconSys consultant shadowed some DRM validators on their initial validations done in residential and non-residential settings. DRM provided ongoing training and mentoring support to validators, including quality reviews of all completed validations prior to those being submitted to the State. EconSys consultants provided the DRM lead staff person with technical assistance and support throughout the process.

Onsite validations were originally scheduled to be completed between February 2020 and October 2020.

Results of the validation assessment for each setting were compared to the provider self-assessment responses. If the provider and the validator both reported compliance, this was treated as compliance and not carried over into the findings report. Where providers reported compliance, but the validation assessment reported noncompliance, this noncompliance was carried over to the findings report. Where providers self-reported noncompliance, this noncompliance was typically affirmed by the validation and carried forward into the findings report. However, if the validation found the setting compliant, the validator’s conclusion held rather than the provider’s report of noncompliance.

Individual Experience Assessment (IEA) Survey

All residential settings that did not receive an on-site validation visit were validated through the combination process described above utilizing IEAs and a mini-desk review.

Care Coordinators and Case Managers were expected to conduct in-person IEAs in the residential setting with the participant (and guardian if one appointed and interested in participating in-person or via phone) receiving services in the setting.

The State and EconSys worked together to develop the draft IEA, with input from DRM (which used a shortened version of the IEA to interview a sample of individuals in the settings where they conducted on-site validations). The draft IEAs were based on examples from other states but customized for use in Maine. In creating the IEA, specific IEA questions were cross walked to the Federal HCBS Settings Rule standards and provider self-assessment questions to ensure validation could effectively occur.⁵⁴ The draft IEAs were shared with the Stakeholder Advisory Committee (SAC) and their feedback was incorporated into an updated draft IEA. Additionally, feedback from Care Coordinators and Case Managers, after they received training on administering the IEA, was incorporated into the final IEA (see Appendix IX) along with feedback from DRM validators who piloted the updated draft IEA in February 2020.

Care Coordinators and Case Managers received training on administering the IEA and additional technical assistance sessions were held to support Care Coordinators and Case Managers as they begun using the IEA tool. Training included the expectation that IEAs must be conducted in a private space separate from setting staff and other participants, so the individual's responses remain confidential. The training stressed the importance of IEAs being completed as a conflict-free assessment in order to ensure the results can be used for setting validation.

Care Coordinators and Case Managers were trained to exhaust all strategies to make it possible for waiver participants to participate in the IEA interview. For example, if the person uses non-traditional modes of communication and lacks the natural supports to help them complete the IEA process, the Care Coordinator or Case Manager was trained to use alternative communication strategies to engage the person to the best of their ability. The goal was to successfully complete IEAs with all individuals in each residential setting so that the minimum threshold number of IEAs necessary for validation could be obtained.

A two-hour training webinar for all MaineCare Care Coordinators and Case Managers was hosted on February 13, 2020. Approximately 270 staff participated in the training. Once IEA administration started, technical assistance calls were hosted monthly to allow Case Managers,

⁵⁴ Specific Federal HCBS Settings Rule standards and provider self-assessment questions that could not be effectively addressed through the IEA were validated through the mini-desk level review described in the next section of this plan.

Care Coordinators and their supervisory personnel to share challenges identified in conducting the IEAs and to discuss strategies for addressing these challenges. Additionally, onsite validators who used a shortened version of the IEA as one component of their comprehensive onsite validation visits were trained on administering these IEAs during onsite validation visits.

All IEAs were originally scheduled to be completed for all settings by July 31, 2020, ensuring the minimum threshold response rate was achieved for all settings.

The responses to specific question(s) from the IEA, cross walked to a specific provider self-assessment question, were compared to the provider's response on that particular self-assessment question. EconSys subject matter experts (SMEs) were trained and provided with tools and ongoing technical assistance from senior SMEs to make the comparison and determine if compliance or noncompliance is evident. Only validated noncompliance was carried over into the findings report for the setting. Where IEA responses for a specific setting were highly inconsistent, the SMEs were trained to elevate these settings to a senior SME and referral for onsite validation if needed. If IEAs appeared to be incorrectly completed, or if less than 75% of the questions had responses recorded, the assigned Care Coordinator or Case Manager was contacted to readminister the IEA.

Desk Level Reviews

Desk Level Reviews of different scopes were used as part of the overall validation process.

Mini-Desk Level Reviews

Settings selected for mini-Desk Level Reviews (mini-DLRs) were those also selected for IEA validation (see Table 19). Specific settings standards and provider self-assessment questions that could not be effectively addressed through the IEA were validated through the mini-desk level review. These included validating:

- The setting's location, assuring it is not co-located with a private or public institution or adjacent to/on the grounds of a public institution.
- The setting provides people receiving HCBS with the choice to receive the services being provided in non-disability specific settings such as supports for integrated employment, volunteering in the broader community, and engaging in integrated activities in the broader community.
- The setting has practices, procedures, and policies to ensure all information about people receiving HCBS is kept private and confidential.
- The setting has a lease, residency agreement or other form of legally enforceable written agreement in place with each person receiving HCBS that lives in the setting, and which provides the same rights, responsibilities and protections from eviction otherwise required under the state's landlord-tenant law or a comparable local ordinance. (Not applicable to Shared Living-Related Family Member Provider settings.)

- The setting offers waiver participants a choice of housemates and if people are sharing a bedroom, they have choice regarding with whom they share the bedroom. (Not applicable to Shared Living-Related Family Member Provider settings.)
- The setting offers waiver participants the choice of a private room if they have the financial resources to afford this. (Not applicable to Shared Living-Related Family Member Provider settings.)

Table 18. Breakdown of HCBS Residential Settings Receiving Individual Experience Assessment and Mini-Desk Review Validations, by Setting Type

Residential Setting Type	IEA/ Mini-DLR	Total	IEA/ Mini-DLR
1-2 Person Group Home	378	470	80%
3-5 Person Group Home	162	261	62%
6-or More Person Group Home	0	36	0%
Family-Centered Home	41	56	73%
Shared Living - Related Family Member is Provider	585	648	90%
Shared Living - Unrelated Provider	329	495	66%
All Settings	1,495	1,966	76%

Mini-DLRs were completed by OADS staff who were trained to conduct these mini-DLRs in March 2020. Initial mini-DLRs completed by each OADS reviewer were reviewed by OADS HCBS initiative manager and EconSys consultant(s) to ensure correct completion of the mini-DLRs was occurring. Ongoing technical assistance from EconSys consultants was available to OADS desk reviewers during the time they were conducting these desk reviews.

Due to the number of mini-DLRs that needed to be completed, and the size of the OADS desk reviewer team, all mini-DLRs were originally scheduled to be completed for all settings by October 2020. For each residential setting receiving this type of validation, the results of the mini-DLRs were combined with the results of the IEAs and displayed as validation results in the setting’s draft findings report. As with IEA results, a trained EconSys SME then made the comparison to the provider self-assessment responses and determined if compliance or noncompliance was evident. Only validated noncompliance was carried over into the findings report for the setting.

Full Desk Level Reviews

Certain settings were validated through a full desk level review (full DLR) if validation through any of the above means proved impossible. A small number of non-residential settings received full Desk Level Reviews due to DRM exhausting its available resources and timeframes for their contract to complete onsite validations. For these settings, an EconSys SME engaged directly with the providers operating these settings and received all documentation of compliance from

the provider to support the self-assessment responses. The EconSys SME conducted the full DLR in order to validate the setting and generate the findings report.

The use of full DLRs for other purposes remains as option; but the originally anticipated need for full DLRs for some residential settings did not become an actual need, due to the success of the IEA and mini-DLR validation process. The State also opted to utilize onsite validation as a ‘back-up’ validation option, preferring this to a full DLR because of the first-hand approach offered through onsite validation.

All validations and finding reports, including the limited number of full DLRs that were required, were originally intended to be completed by December 2020 as the state worked toward ensuring full compliance by March 2022. The next section details the impact of the COVID-19 pandemic on the validation processes and timelines.

Impact of COVID-19 on Validation Schedule and Methods

As noted above, onsite validation visits and mini-DLRs were originally scheduled to be completed by October 2020 and IEAs were scheduled to be completed in July 2020. When the COVID-19 pandemic began, the state took steps to prevent the spread of the virus and protect the health and safety of waiver participants, provider staff and onsite validators.

Due to COVID-19, all validation processes had to be paused from April 13 to June 12, 2020. Then, between June 15 and July 10, 2020, setting validations resumed only in certain areas of the state (Districts 6, 7, 8 which includes Aroostook, Piscataquis, Penobscot, Hancock, and Washington counties) where there were no currently reported COVID-19 cases or community transmission for waiver participants. Within these three districts, the HCBS validation process resumed for settings that had no confirmed COVID-19 cases.

On July 9, 2020, the state announced that setting validations could continue in Districts 6, 7, 8. However, onsite validations by Disability Rights Maine (DRM) were transitioned to a remote/virtual format. Additionally, other validation strategies that could be conducted virtually/remotely were begun or continued including Mini Desk Level Reviews conducted remotely by OADS staff and the piloting of virtual IEAs introduced in Districts 3, 4 and 5. Finally, for providers operating residential settings located outside of the six districts noted above and originally selected for onsite validation by DRM, the state offered the option to schedule a virtual/remote validation with DRM if the settings had no confirmed COVID-19 cases.

On August 17, 2020, the state announced that residential setting validations (all types) would resume statewide with all onsite validations by DRM changed to virtual/remote validation format. This was decided after extensive consultation with DRM and determination that the virtual/remote format was an effective alternative to onsite validation. Other residential setting validations conducted using Mini DLRs and IEAs resumed statewide with encouragement of in-

person IEAs conducted safely outside whenever possible or virtual/remote IEAs if in-person format was not possible. The state’s decision to permit virtual/remote IEAs was reached after evaluating the piloting of this approach, incorporating specific evaluation questions for Care Coordinators/Case Managers to answer after the completion of each virtual/remote IEA. The date received (see Table 19) illustrates the switch to virtual/remote administration of the IEA did not impact the validity of the IEA responses.

Table 19. Results of evaluation of virtual/remote IEAs

Questions	Yes Responses
In your opinion, was the person able to reflect on life before COVID-19 in providing responses?	78%
In your opinion, was the person able to reflect on their typical life experiences and opportunities outside of those impacted by COVID-19?	80%
Did the fact the IEA was done virtually and not in-person, negatively impact the person’s ability to participate?	92%
Did the fact the IEA was done virtually and not in-person, negatively impact the person’s willingness to participate?	94%

Additionally, the state announced that non-residential settings yet to be validated would receive onsite validations by DRM and OADS staff. The state required that these onsite validations be done using a “safe practices” approach. The state communicated intent to complete all of residential and non-residential validations by December 31, 2020, two months later than the original target date of October 31, 2020.

Then, in November of 2020, the state determined that, due to COVID-19, validations of Community Supports service settings must be paused until April of 2021. This pause extended the state’s deadline for completing all Community Supports setting validations to June 30, 2021. All of these carefully considered pauses were designed to continue setting validation as expeditiously as possible, while taking appropriate steps in light of the COVID-19 pandemic. The combination of pauses impacted the timeframe for when settings received their findings reports, which impacted the remediation process described next. While all validation activities were originally to be completed by October 1, 2020, and findings reports for all settings were originally to be issued by October 31, 2020, with all of the COVID-19 pauses in the process, all validation activities were completed by June 30, 2021, and nearly all findings reports were issued by July 31, 2021. While CMS extended by one year the final deadline for states to achieve full compliance to March 17, 2023, the impact of COVID-19 caused the State’s process to be delayed by nine months which largely eliminated the benefit of the one-year extension to the final deadline.

Results of Setting Validation

Providers were expected to receive the results of a setting validation within 30 days of the validation process being completed for that setting. Although COVID-19 created challenges with this, findings reports for the vast majority of settings were issued to providers within 30 days of validation being completed.

The following tables report the validation findings, by setting type, classifying settings in one of four possible validation categories.

Table 20. Settings found to be fully compliant with HCBS settings criteria

Setting Type	Setting Count
Residential	0
1-2 Person Group Home	0
3-5 Person Group Home	0
6-or More Person Group Home	0
Family-Centered Home	0
Shared Living - Related Family Member is Provider	0
Shared Living - Unrelated Provider	0
Non-Residential	0
Club House	0
Community Supports	0
Work Support-Group	0
Total	0

Table 21. Settings found capable of becoming fully compliant with HCBS settings criteria with modifications during the transition period

Setting Type	Setting Count
Residential	1,966
1-2 Person Group Home	470
3-5 Person Group Home	261
6-or More Person Group Home	36
Family-Centered Home	56
Shared Living - Related Family Member is Provider	648
Shared Living - Unrelated Provider	495
Non-Residential	179
Club House	1
Community Supports	165
Work Support-Group	13
Total	2,145

Table 22. Settings found unable to comply with HCBS settings criteria

Setting Type	Setting Count
Residential	0
1-2 Person Group Home	0
3-5 Person Group Home	0
6-or More Person Group Home	0
Family-Centered Home	0
Shared Living - Related Family Member is Provider	0
Shared Living - Unrelated Provider	0
Non-Residential	0
Club House	0
Community Supports	0
Work Support-Group	0
Total	0

Table 23. Settings found to be presumptively institutional in nature but for which the state will, subject to public comment, submit evidence for the application of heightened scrutiny

Setting Type	Setting Count
Residential	104
1-2 Person Group Home	32
3-5 Person Group Home	28
6-or More Person Group Home	13
Family-Centered Home	3
Shared Living - Related Family Member is Provider	7
Shared Living - Unrelated Provider	21
Non-Residential	78
Club House	0
Community Supports	78
Work Support-Group	0
Total	182

For more information on setting classified as “presumptively institutional”, please see the section of this STP specifically discussing the heightened scrutiny process. Additionally, a more detailed summary of aggregate validation compliance results across these settings, by setting type, is included in Appendix VII and is also posted on the OMS and OADS HCBS website for public review. Similar to other states’ experiences, the level of compliance confirmed through validation was not as high as providers had self-reported through the setting assessment process.

Summary of Most Common Validation Results for Residential Settings

The most common areas of compliance, confirmed through validation, across all types of residential settings included the following:

Table 24. Most common areas of compliance, confirmed through validation, across all types of residential settings

Compliance Expectation	% of Residential Settings Validated as Fully Compliant
Privacy afforded when providing supports for activities of daily living.	99%
Individuals able to keep earnings from employment.	99%
Opportunity to receive support from residential staff outside of the residential setting in the broader community.	98%
Dignity, choice and age-appropriate support during dining in dining area that is accessible and comfortable.	98%
Physical accessibility of the setting for individuals residing in the setting.	97%
Opportunities and support for individuals to shop for their own food and groceries.	97%
Providing access to food at any time.	97%
Providing a secure place for individuals to store personal belongings other than financial resources.	95%
Staff knock before entering an individual’s private space.	94%
Individuals can have a meal or snack at a time and place they choose.	94%
Average level of compliance for all residential settings:	80.69%

The most common areas of noncompliance, confirmed through validation, across all types of residential settings included the following:

Table 25. Most common areas of noncompliance, confirmed through validation, across all types of residential settings

Compliance Expectation	% of Residential Settings Validated as <u>Not</u> Fully Compliant
Adequate practices, procedures, and policies to ensure all information about people receiving HCBS is kept private and confidential.	67%
Lease, residency agreement or other form of legally enforceable written agreement in place with people receiving HCBS that live in the setting and which provides the same rights, responsibilities and protections from eviction otherwise required under the state’s landlord-tenant law.	59%
Ensuring staff are sufficiently trained on integrated employment and Employment First values and practices.	57%

Compliance Expectation	% of Residential Settings Validated as <u>Not</u> Fully Compliant
Providing flexible access to transportation for individuals to access the broader community and engage with members of the broader community and ensuring individual know all options for transportation available to them.	51%
Enabling individuals to keep secure possession of their personal financial resources where they choose without access to personal financial resources being dependent on presence of staff.	53%
Supporting individuals to explore the possibility of working integrated employment if they are not already doing so.	49%
Ensuring individuals can have visitors at any time.	48%
Offering individuals the opportunity to receive the services provided in non-disability specific settings.	44%
Providing lockable doors to private spaces with only the individual and appropriate staff having keys.	42%
Average level of non-compliance for all residential settings:	19.31%

Summary of Most Common Validation Results for Non-Residential Settings

The most common areas of compliance, confirmed through validation, across all types of non-residential settings included the following:

Table 26. Most common areas of compliance, confirmed through validation, across all types of non-residential settings

Compliance Expectation	% of Non-Residential Settings Validated as Fully Compliant
Using a setting location that is near other community venues like parks; indoor/outdoor recreational activities; colleges/universities; libraries, community centers, job centers, restaurants; retail stores; and religious places of worship.	96%
Providing opportunities for people to interact with members of the broader community not receiving HCBS when the setting is supporting people to work in integrated settings.	95%
Ensuring people can choose with whom they spend their time while at the setting.	93%
Ensuring the setting’s physical environment provides options to meet individual goals and needs related to physical environment.	92%
Supporting people by providing assistance with activities of daily living while ensuring the privacy of the person.	91%
Supporting people to choose where they keep their personal financial resources (cash; checkbook; bank card; credit cards) when at the setting.	91%
Providing transportation for people receiving HCBS to and from the broader community when requested.	89%

Compliance Expectation	% of Non-Residential Settings Validated as Fully Compliant
Using a setting location that is close to other businesses and community venues open to the public that have people coming and going from the broader community.	89%
Offering support for a person working in integrated employment to engage in non-work activities if the person has support needs when s/he is not working and does not have another service provider involved.	88%
Average level of compliance for all non-residential settings:	61.38%

The most common areas of noncompliance, confirmed through validation, across all types of non-residential settings included the following:

Table 27. Most common areas of noncompliance, confirmed through validation, across all types of non-residential settings

Compliance Expectation	% of Non-Residential Settings Validated as <u>Not</u> Fully Compliant
Providing meaningful person-centered assessments about what is important and valuable to a person in regard to integrated work if the person is not already working in integrated employment; and having formalized goals to increase the number of people served who are working in integrated employment.	95%
Offering options for people receiving HCBS to choose to receive the waiver service exclusively in integrated, community-based, non-disability specific settings.	84%
Provide training and support to people receiving HCBS about informed decision making and autonomy and ensuring support for informed choice.	82%
Ensuring practices, procedures, and policies are responsive to the goals and support needs of each person who receives HCBS, as defined in their person-centered plan and the setting’s individual service plan.	76%
Encouraging people who do not receive HCBS and who are not paid staff or volunteers to spend time in the setting.	74%
Providing opportunities and supports for people receiving HCBS to seek integrated employment.	70%
Ensuring all direct support staff are trained in person-centered planning.	68%
Providing opportunities and supports that focus on the goals, preferences and needs of each person and provide an opportunity for personal growth and new learning (e.g., take up a new hobby or learn a new skill, expanding relationships, expanding experiences).	67%
Average level of noncompliance for all non-residential settings:	38.62%

As mentioned above, for more detailed aggregate data resulting from validation, please see Appendix VII.

Phase 3: Remediation of Settings: Transition-to-Compliance

Based on the validation results for each setting outlined in the setting's findings report, each setting was supported to develop and submit a transition-to-compliance plan (TTCP) for the setting. The TTCP is a critical part of the transition process because it documents the provider's proposed remediation which is approved by the state, and this approved remediation in the TTCP is then the objective standard used to evaluate actual evidence of remediation subsequently submitted by the provider.

DHHS provided the findings report in a Microsoft Excel format that included fields for the provider to insert their proposed remediation to address each area of noncompliance. To be clear about the State's expectations with remediation, and to avoid providers feeling they must guess at what type and level of remediation might be acceptable, the findings report included a column that described minimum expected remediation and optional remediation. Providers proposed the remediation they intended to complete, either drawing from the statements describing minimum expected and optional remediation or proposing their own remediation to address the noncompliance. The provider also filled in the target date by which they planned to complete the proposed remediation for each area of noncompliance. The provider then submitted the proposed TTCP to the State via the HCBS Compliance Portal. As of the posting of this Final STP, providers had submitted a proposed TTCP for 99.5% of active settings requiring remediation.

EconSys' trained SMEs reviewed each TTCP proposed by a provider and determined if the plan could be approved as submitted or with specific changes. If any changes were required to approve a TTCP, the SME entered those changes directly into the TTCP, with an explanation, and uploaded the approved TTCP to the Portal. The provider was then notified the approved TTCP for the setting was available in the Portal. The provider could view and download the approved TTCP, noting any changes the SME identified as required for approval. The provider then indicated acceptance of the TTCP via the Portal and the TTCP became the setting's plan for coming into full compliance. As of the posting of this Final STP, 99.99% of active settings with proposed TTCPs had their TTCPs approved by the state.

Timeframes for Setting Remediation

Timeframes for settings to reach full compliance have been revised multiple times to take account of the one-year extension for states granted by CMS, the impact of the COVID-19 pandemic and the direct service workforce shortage being experienced by Maine's HCBS providers. When the state expected its final deadline for full compliance would be March 17, 2022, settings were expected to be in full compliance by October 31, 2021. This goal was set to ensure the State had sufficient time to verify full compliance of all settings and if necessary, allow DHHS sufficient time to facilitate the relocation of HCBS participants to alternative compliant settings by the March deadline to avoid loss of FFP for these HCBS participants' services.

When CMS extended the final deadline to March of 2023, DHHS initially proposed to extend the final deadline for providers of services at settings in existence prior to March 17, 2014 in the proposed Global HCBS Waiver Rule to July 31, 2022. As COVID-19 impacts and workforce shortage issues continued to mount, and in response to public comments regarding the proposed rule seeking more time for providers, the state revised this deadline to September 30, 2022, when it adopted the [Global HCBS Waiver Rule](#). The state did not adopt October 31, 2022 as the deadline, due to the fact that the state recognized it must account for requirements to give formal notice to providers and HCBS participants if DHHS must terminate the use of a setting for HCBS due to failure to achieve full compliance. The September 30, 2022 deadline allows necessary time to incorporate the notice requirement into the timeline while still ensuring DHHS will have sufficient time to facilitate the relocation of HCBS participants to alternative compliant settings by the March 17, 2023 deadline to avoid loss of federal match funding for these HCBS participants' services. Settings that came into service on or after March 17, 2014 were required to be compliant with applicable settings requirements in the Global HCBS Waiver Rule by January 19, 2022.

Progress Updates and Ongoing Collaboration to Support Provider Success in Bringing Settings into Full Compliance

The State and EconSys have established a “Progress Update” schedule for providers to submit evidence of completed remediation for review and approval on a rolling basis. When the Department expected that the deadline for compliance would be March 17, 2022, providers would have had a minimum of twelve months to fully remediate (Oct 2020- Oct 2021). Given this, the expectation of quarterly progress updates was established. When CMS extended the state's final deadline to March 17, 2023 – enabling the Department to extend the deadline for providers in the Global HCBS Waiver Rule to September 30, 2022 – the expectation was changed to semi-annual progress updates to avoid unnecessary burden on providers.

To submit a progress update, the provider downloads the approved TTCP which contains columns for each of the progress updates. The provider enters brief descriptive updates of the remediation completed and references the specific evidence uploaded to the Portal to demonstrate this remediation. The provider then uploads the TTCP to the Portal. The assigned EconSys SME then reviews the progress update included in the TTCP and approves remediation or if approval cannot be granted, provides feedback on what additional evidence of remediation is necessary for approval. The SME then uploads the TTCP to the Portal and the provider gets a notification it has been uploaded with the SME feedback.

To facilitate provider success in bringing settings into full compliance, the State and EconSys recently made changes to the process, both in response to the challenges providers are facing and in response to providers asking for increased assistance with completing remediation. Providers now continue to have the option to submit progress updates semi-annually; but providers also have the option to submit more frequent, real-time progress updates as they complete smaller

pieces of the required remediation. Providers can submit progress updates that address only certain remediation. SMEs are then prompted to review the update and provide approval or feedback. The more frequent “back and forth” between the provider and SME is expected to support more rapid and successful provider efforts to achieve full remediation. As of the posting of this Final STP, providers have submitted 89.6% of first progress updates for settings and 74.2% of second progress updates. To date, only 12% of progress updates have not been received by the target dates.

The state and EconSys recognize that maximizing practical assistance to providers is critical to help them meet the compliance deadlines in the Global HCBS Waiver Rule. To this end, the state has allocated new funding to increase the technical assistance EconSys SMEs can provide. This includes working with providers on a one-on-one basis regarding their remediation efforts, drafting and providing sample policies, procedures and practice tools, continuing to ensure sharing of best practices from other settings and states, and helping providers with multiple settings tackle their remediation strategically based on common findings across settings. In addition, monthly provider webinars will continue to be hosted and other special-topic webinars will be held as providers identify a need for these.

Phase 4: Final Compliance Determinations and Relocations

As noted above, all TTCPs for settings established prior to March 17, 2014 must be fully implemented (all remediation completed) by September 30, 2022 under the Global HCBS Waiver Rule. EconSys will continue to monitor progress on remediation for all providers and settings. They will continue to provide regular updates to the providers (on the monthly webinars), the ESC and the SAC. Once the September 30, 2022 deadline has passed, EconSys will make final determinations regarding each setting’s compliance status by reviewing any new progress updates and evidence submitted to the Portal by the September 30th deadline. By November 15, 2022, EconSys will notify DHHS and the ESC of the final compliance determination for each setting. All settings will receive official correspondence from DHHS confirming their final compliance determination and explaining the planned approach for ongoing monitoring to ensure setting compliance is maintained over time. The SAC will be updated on final compliance determinations no later than its December 2022 meeting.

Supporting Participants who Must Relocate to Fully Compliant Settings Before the End of the Transition Period

As noted above, if any setting is not determined to have reached full compliance, the state is required to provide formal notice to the setting, and participants receiving services in the setting, of the need to terminate use of the setting for HCBS by March 17, 2023. To meet this deadline, DHHS must provide notice by no later than December 17, 2022. After notice, the Care Coordinators/Case Managers for the participants that need to relocate will engage these participants and their person-centered planning teams to ensure each participant makes an

informed choice of the setting to which they wish to transition by March 17, 2023. Efforts by the Care Coordinator/Case Manager and involved provider(s) will ensure a safe and orderly transitions for these individuals so they can continue to receive HCBS in compliant settings without any interruption in services or reduction in available funding for those services.

The state will use the following process to assure participants are properly supported in making any transitions to a new setting:

- Initial Notice (by 12/17/22): Contact the participant, participant's guardian and/or family members to provide initial information of the timeline required for transition and the options of other settings available near the participant's existing setting.
- Person-Centered Process for Choosing New Setting: Case Manager and/or Care Coordinator will schedule a meeting with the participant and the participant's person-centered planning team to discuss alternative setting options available, and to develop a plan for making the sure the participant has an opportunity to explore the other available options in order to make an informed choice.
- Transition Timeframe (by 3/17/23): The member will receive a minimum of 120 days to transition from their current setting to a fully compliant setting where they can continue to receive needed services.
- Post-Transition Monitoring (through 3/17/25): OADS will review Care Coordinator/Case Manager documentation on any participants that transition as a result of setting noncompliance with Federal HCBS requirements on a quarterly basis for the two years following the transition to monitor the participant's experience and to ensure the new setting is adequately and effectively meeting the participant's needs.

Phase 5: Ongoing Monitoring & Quality Assurance

Similar to the approach used for setting validation, DHHS is taking a multi-pronged approach to ongoing monitoring of settings.

Provider Owned or Controlled Residential Settings, Disability-Specific Non-Residential Settings and HCBS Presumed Compliant Settings

Three types of ongoing monitoring will be utilized with waiver providers delivering HCBS in provider owned or controlled residential settings, Shared Living-Related Caregiver settings, disability-specific non-residential settings, and presumed compliant HCBS settings in Sections 18, 20, 21, and 29 waivers. Ongoing monitoring includes individual experience assessments completed with participants, on-site compliance visits and desk level reviews.

The state expects every provider owned or controlled residential setting, Shared Living-Related Caregiver setting, and disability-specific non-residential setting will receive an on-site visit at least once every three to five years. These visits will include a site survey and individual experience assessment interview with a select number of waiver participants. Providers found to

be out of compliance with the state's Global HCBS Waiver Rule will be issued a letter requesting the provider to submit a plan of corrective action.⁵⁵ Failure to complete the plan may jeopardize the agency's ability to participate as a provider of HCBS services. Providers will be provided a notice of appeal accompanying a request to submit a plan of corrective action and the provider will follow the appeal process if they wish to appeal as outlined in MaineCare Benefits Manual Chapter I, Section 1.

In addition, providers will be required to complete and submit an HCBS Attestation form in conjunction with their Office of MaineCare Services revalidation cycle.

Ongoing training for providers on the state's Global HCBS Waiver Rule will be provided during annual/biannual training sessions hosted by the state as well as through participation in meetings with provider membership organizations and oversight and advisory boards.

- Individual Experience Assessments (IEAs):

OADS will request IEAs to be completed from a selected number of participants per provider setting. All completed IEAs will be reviewed and assessed to ensure the setting remains in full compliance with the state's Global HCBS Waiver Rule. The IEA will reflect the participant's experience in the HCBS setting and allow the state to collect and utilize the information to determine to what extent participant's experiences are consistent with the state's Global HCBS Rule standards in the setting they receive HCBS.

- Any substantial discrepancies between the total participant responses for the agency and compliance with one or more of the state's Global HCBS Waiver Rule standards will result in the provider being contacted by the regional quality assurance team to determine whether the provider has evidence that supports continued compliance with the standard(s) in question, and if not, to implement a plan of correction process.⁵⁶
- As plans of correction are submitted, the state will review the plans and accompanying documentation and respond via a letter to the provider. Follow-up by DHHS will occur to ensure corrective actions, once approved, are implemented.

- Onsite Compliance Visits:

OADS and/or contracted entity will conduct onsite compliance visits for selected settings who deliver HCBS in provider owned or controlled residential settings, Shared Living-Related Caregiver settings, and disability-specific non-residential settings as an ongoing monitoring strategy when that setting has not received an on-site compliance visit in the previous three-to-five-year cycle.

⁵⁵ Providers have the right to appeal written notices of deficiencies per MAINECARE BENEFITS MANUAL, Ch. I.

⁵⁶ MBM Ch. I, Sec. 1, § 1.20-1Q).

- Any substantial discrepancies between the total participant responses for the agency and compliance with the state’s Global HCBS Waiver Rule standards will result in the provider being required to submit and implement a corrective action plan based upon written findings by the Department.⁵⁷
- As corrective action plans are submitted, the state will review the plans and accompanying documentation and respond via a letter to the provider. Follow-up site visits may occur as a result of the review with providers to ensure corrective actions, once approved, are implemented. If additional site visits are required, the provider will receive additional communication summarizing the visits and findings.

- **Desk Level Reviews:**

OADS will conduct desk level reviews with selected HCBS provider owned or controlled residential settings, Shared Living-Related Caregiver settings, and disability-specific non-residential settings selected each year for this type of compliance review. OADS will assure a provider selected for desk level review engaged in a full onsite review in the previous three-to-five-year cycle.

- Any deficiencies in substantial compliance with one or more of the state’s Global HCBS Person-Centered Planning and Settings Rule standards will result in the provider being required to implement an approvable plan of correction.⁵⁸
- As plans of correction are submitted, the state will review the plans and accompanying documentation and respond via a letter to the provider. Follow-up by DHHS will occur to ensure corrective actions, once approved, are implemented.

Other Types of HCBS Settings the State could Presume Compliant During the Transition Period

The Section 19 waiver does not utilize provider owned or controlled residential settings or disability-specific non-residential settings. All services in the Section 19 waiver and some services in the other four waivers are delivered in people’s privately-owned/leased homes and other individualized integrated community settings that are not provider owned or controlled and also not disability-specific settings. However, DHHS must still address ongoing monitoring for these settings, when the provision of HCBS occurs, to ensure each participant’s experience is consistent with the state’s Global HCBS Waiver Rule. Therefore, DHHS intends, beginning in March of 2023, to adopt the following approach:

- Conduct an annual Individual Experience Assessment (IEA) interview with all Section 19 participants. With participants on the Section 18, 20, 21 and 29 waivers, a provider

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

agency will be selected once every five years and in the selected year, all participants served by the provider agency will receive an IEA. The IEA will address the participant's experiences in these HCBS settings and collect information to allow the state to determine to what extent participants have an experience consistent with the state's Global HCBS Rule.

- In Section 19, this process will not be conducted as part of the PCP process, but instead is planned to be a stand-alone process that will be done telephonically. Results will be available in real time for OADS LTSS managers or quality assurance staff to review.
- Any discrepancies between participant responses and compliance with one or more of the Federal HCBS Settings Rule general standards, reflected in the state's Global HCBS Waiver Rule, will result in the appropriate provider(s) for the member being contacted by LTSS quality assurance staff to determine whether the provider has evidence that supports continued compliance with the standard(s) in question, and if not, sixty (60) days will be granted for the provider to change practices with the participant in question and provide the evidence. If evidence is not sufficient after sixty (60) days, LTSS will implement a plan of correction process⁵⁹ with the provider.
- OADS managers will flag areas that need further review/follow up with Care Coordinators and/or providers to correct situations where participants' experiences are not fully consistent with the Global HCBS Waiver Rule.
- In Sections 18, 20, 21, and 29, case managers will conduct IEAs as part of their case management monitoring functions.
- Any substantial discrepancies between the aggregate participant responses for the provider agency and compliance with one or more of the standards in the state's Global HCBS Waiver Rule, will result in the provider being contacted by the OADS regional quality assurance team to determine whether the provider has evidence that supports affirmative compliance with the standard(s) in question. If not, the provider will be required to implement an approved plan of correction.⁶⁰
- As plans of correction are submitted, the state will review the plans and accompanying documentation and respond via a letter to the provider. Follow-up by DHHS will occur to ensure corrective actions, once approved, are implemented.

Case Management/Care Coordination Agencies

OADS will conduct a review of a 10% randomly selected sample of person-centered service plans (PCPs/PCSPs) including HCBS Rights Modifications, from each case management/care coordination agency every three years. These reviews will further strengthen the state's existing

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

approach to ensuring continued compliance with person-centered service planning requirements in the state’s Global HCBS Waiver Rule.

- OADS will provide a report to the agency under review on the findings of the review and assessment. Any deficiencies in substantial compliance with the state’s Global HCBS Waiver Rule standards will result in the State issuing written notices of deficiencies⁶¹ and requiring the provider to submit and implement plans of corrective action as approved by the Department.
- As plans of correction are submitted, the state will review the plans and accompanying documentation and respond via a letter to the provider. Follow-up by DHHS will occur to ensure corrective actions, once approved, are implemented.

The above approach to ongoing monitoring within the MaineCare HCBS waiver system will assure that all MaineCare HCBS settings are regularly monitored on an ongoing basis for full compliance with the Global HCBS Waiver Rule.

DHHS, including OMS and OADS, recognizes that a key component of ongoing monitoring is also the provision of continued technical assistance and training opportunities for providers, Care Coordinators/Case Managers, participants, and their allies (e.g., family, friends, and guardians). DHHS is committed to continue working with all of these stakeholders and advocates to determine what strategies can be deployed to continue to facilitate the use of promising practices in waiver service provision to ensure continuous quality improvement in the state’s HCBS waiver programs.

⁶¹ Providers have the right to appeal written notices of deficiencies per MBM, Ch. I.

Heightened Scrutiny Process

Overview of Heightened Scrutiny Process

As noted earlier in the discussion of Federal HCBS Settings Rule requirements, Maine has policy that pre-dates the federal rule and prohibits the delivery of HCBS in two of the three types of settings that the federal rule defines as “presumptively institutional and therefore subject to a heightened scrutiny process. Particularly, “Prong 1” and “Prong 2” presumptively institutional settings are defined as follows:

- Prong 1: Any setting located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment
- Prong 2: Any setting located in a building on the grounds of, or immediately adjacent to, a public institution.

Because Maine policy does not allow HCBS in these settings, the state conducted validation through desk review or onsite review verified that no HCBS settings fell under Prong 1 or Prong 2. For desk reviews, the state verified settings were not Prong 1 or Prong 2 using Google Maps and provider-submitted photographs. For onsite reviews, the verification was done by onsite reviewers doing in-person assessment of the settings’ locations. As a result, Table 28 depicts the fact that validation identified no Prong 1 or Prong 2 settings in Maine’s existing HCBS system.

Table 28. Settings identified as Prong 1 or Prong 2 presumptively institutional settings

Setting Type	Setting Count
Residential	0
1-2 Person Group Home	0
3-5 Person Group Home	0
6-or More Person Group Home	0
Family-Centered Home	0
Shared Living - Related Family Member is Provider	0
Shared Living - Unrelated Provider	0
Non-Residential	0
Club House	0
Community Supports	0
Work Support-Group	0
Total	0

Therefore, in Maine, the heightened scrutiny process requires the Department to identify through assessment and validation, settings that fall under “Prong 3” as defined in the Federal HCBS Settings Rule. Prong 3 settings are any HCBS settings, other than Prong 1 or Prong 2 settings,

that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

To remain HCBS waiver providers, the providers of services at such settings will be able to develop and submit an evidentiary package (EP) which provides specific evidence of how the setting will address its characteristics that isolate HCBS participants from the greater community and address any other setting standards that the validation process determined were not fully met. The EP must document how participants served in the setting will, after remediation, have the same degree of access to the broader community, its community members, and community activities chosen through informed choice, as individuals not receiving MaineCare HCBS.

Where the Department determines that an EP for a heightened scrutiny setting contains sufficient evidence that the isolating characteristics of the setting can be overcome, and all other setting standards can be met, a conclusion that the setting can overcome its institutional qualities is supported and accordingly, DHHS will post the setting for public comment with a statement that the state intends, subject to public comment, to submit the setting to CMS for heightened scrutiny review. Likewise, in the absence of sufficient evidence that the isolating characteristics of the setting can be overcome, and all other setting standards can be met, a conclusion that the setting is institutional holds, and accordingly, DHHS posts the setting for public comment with a determination that the state intends, subject to public comment, not to submit the setting to CMS for heightened scrutiny review. After public comment, the ESC makes a final determination on whether to submit each setting to CMS for heightened scrutiny review, seeking approval to maintain the setting for HCBS after March 17, 2023. CMS makes the final determination for each setting submitted for heightened scrutiny. If CMS concludes the setting may be retained for HCBS, the setting must still fully implement all required remediation per its approved TTCP.

Process for Identification of Settings that Isolate

As discussed earlier in this plan, in designing the residential and non-residential provider self-assessments, DHHS followed CMS guidance regarding identification of settings that have an **isolating effect**:

CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid-funded 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* for interaction in and with the broader 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; or*
- *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.

**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.*

Source: State Medicaid Directors Letter #19-001 issued 3/22/2019; Page 3.⁶²

Questions 3 through 6 on both the residential and non-residential provider self-assessments (see Appendix IX.1) tracked the above guidance closely:

1. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community, including the broader community of individuals not receiving Medicaid-funded HCBS?
2. Due to model used for service provision, do individuals have limited opportunities – as compared to individuals living in the same community that do not receive HCBS - for interaction in and with the broader community, including interactions with individuals not receiving Medicaid HCBS?
3. Does the setting restrict and/or limit individuals’ choices to receive services provided by the setting outside of the setting or to engage in activities outside of the setting?
4. Is the setting physically located separate and apart from the broader local community?

Source: Maine Non-Residential and Residential Setting Self-Assessment Tools

Tables 29 and 30 contain the provider self-assessment results for these questions.

Table 29. Percentages of Self-Reported Non-Compliance on Isolating (Presumptively Institutional) Setting Status (Residential)

Residential Setting Type	Q3	Q4	Q5	Q6	Total Number of Settings*
1-2 Person Group Home	0.0%	3.0%	1.1%	7.9%	468
3-5 Person Group Home	0.4%	1.5%	0.4%	10.7%	261
6-or More Person Group Home	0.0%	2.8%	0.0%	25.0%	36
Family-Centered Home	3.8%	0.0%	0.0%	9.4%	53
Shared Living - Related Family Member is Provider	0.5%	0.9%	0.3%	27.8%	648
Shared Living - Unrelated Provider	0.6%	0.8%	0.4%	30.7%	495
All Settings	0.5%	1.5%	0.5%	21.0%	1,961

*Not including 5 settings that did not complete a self-assessment and 120 settings that completed a self-assessment which were subsequently no longer being used for HCBS as of the date this analysis was compiled (2/8/2020).

⁶² See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf> (accessed February 8, 2022).

Table 30. Percentages of Self-Reported Non-Compliance on Isolating (Presumptively Institutional) Setting Status (Non-Residential)

Non-Residential Setting Type	Q3	Q4	Q5	Q6	Total Number of Settings*
Club House	0.0%	0.0%	0.0%	0.0%	1
Community Supports	2.5%	6.1%	2.4%	5.5%	165
Work Support-Group	0.0%	0.0%	0.0%	21.4%	13
All Settings	2.3%	5.6%	2.2%	6.7%	179

The validation process used the same four questions found on the self-assessment as the primary method for identifying if a setting is isolating; however, additional validation steps and factors were utilized to ensure accurate identification of isolating settings, with the intent to prevent both under-identification and over-identification. All DRM onsite validators and EconSys SMEs determining whether validation supported questions 3-6 being marked “yes” for a setting were trained to always make these determinations as the last step in their work. DRM onsite validators were trained to complete the remainder of the validation assessment before coming back to answer questions 3-6, to be sure they took account of all results of the validation assessment process in determining whether a setting met the standards for having isolating characteristics. EconSys SMEs were trained to review all IEA and mini-DLR data against the provider self-assessment responses to determine all other compliance and noncompliance for a setting before making a determination regarding whether the IEA and mini-DLR data supported a conclusion that the setting isolates.

Additionally, given Maine is a very rural state, it was anticipated that a high proportion of residential settings in particular would be physically located separate and apart from the broader local community (i.e., Q6 would be marked “yes”). This was borne out by the results of the provider self-assessments noted above. However, being physically located separate and apart from the broader local community did not automatically result in a conclusion that a setting was isolating. Therefore, for both residential and non-residential settings, if at least one of questions 3, 4, and 5 was also answered positively (either on the onsite validation assessment or supported by IEA responses from members receiving HCBS in the setting), this would trigger the setting being advanced to the next step of review process for possible isolating characteristics. This triggered an additional review even if question 6 was not answered “yes”. Additionally, for non-residential settings, if question 6 was the only question marked yes from among questions 3-6, additional consideration was given to the validation assessment answers for ten (10) other specific questions which were identified as providing important additional information and context about the setting’s policies, practices, and characteristics relevant to accurately determining if the setting isolates. A consistent, systematic approach was used to apply the results for these additional ten questions and determine if the non-residential setting should be sent for additional review.

With regard to this additional review step, the EconSys team established a dedicated SME for heightened scrutiny settings. Having one SME handle all heightened scrutiny settings increased consistency in the process used to identify settings that are isolating. Any setting with initial validation results that suggested isolating characteristics was forwarded to this SME for a closer, secondary review to reach a final determination. This SME used a consistent, systematic approach to conducting this secondary review and reaching a final determination as to whether the setting isolates. Comparisons to other settings sent for review were done to ensure consistent findings regarding settings determined to isolate.

As Tables 30 and 31 illustrate, providers self-assessing their settings did not find most of their settings to affirmatively align with what is described in Q3 through Q5. However, a higher percentage of non-residential settings than residential settings answered these questions affirmatively which ultimately aligned with the results of setting validation in that a greater percentage of nonresidential settings were found to be isolating as compared to residential settings. And similar to other states’ experiences, independent validation also resulted in a greater number of settings being determined isolating than provider’s self-reported through the self-assessment process.

Settings Identified as Subject to Heightened Scrutiny

A total of 228 settings that were validated were sent for additional review to determine if they were presumptively institutional due to being isolating. As noted in Table 31, 188 (12% of total active settings) were determined to have isolating characteristics (presumptively institutional under Prong 3). No settings were found to fit Prong 1 or Prong 2 as noted previously.

Table 31. Statistics on Settings Reviewed and Identified as Presumed Institutional

Type of Setting	Prong #1	Prong #2	Prong #3 (Isolating)	7.1.21 Full Compliance	Settings Closed	EPs anticipated to be sent to CMS
6+ Group Home	N/A	N/A	13	0	0	13
3-5 Group Home	N/A	N/A	24	0	8	16
1-2 Group Home	N/A	N/A	30	2	6	24
Family-Centered Home	N/A	N/A	5	2	2	1
Shared Living-Unrelated	N/A	N/A	15	2	6	7
Shared Living-Related Family Member	N/A	N/A	7	1	1	5
Community Supports	N/A	N/A	82	0	14	68
Settings Closing	N/A	N/A	12	N/A	N/A	N/A
TOTAL	N/A	N/A	188	5	37	146

*Note: Maine policy prohibits the delivery of HCBS in settings that are defined as Prong 1 or Prong 2.

Opportunity for Settings to Avoid Full Heightened Scrutiny Process

Per the process described and approved by CMS in the state's initial Statewide Transition Plan, the state expects all settings determined to require remediation, including isolating settings, to have an approved Transition-to-Compliance Plan (TTCP). As noted previously, the TTCP is a critical part of the transition process because it documents the provider's proposed remediation which is approved by the state, and this approved remediation in the TTCP is then the objective standard used to evaluate actual evidence of remediation subsequently submitted by the provider. For settings that are found to be isolating through the state's setting assessment and validation process and who submitted a TTCP that was approved by the state, a time-limited opportunity to bring the setting into full compliance and avoid the full heightened scrutiny process, became available as a result of CMS extending the final deadline for states to March 17, 2023.

CMS guidance to states⁶³ issued in March 2019 indicated that any setting a state determines, through assessment and validation, to be isolating had until July 1, 2020, to fully remediate such characteristics in order to avoid requiring a heightened scrutiny review by CMS. The state's setting validation process was originally subject to a very compressed timeline running from February to October of 2020. The state anticipated few if any settings, found to be isolating during validation, being able to meet the July 1, 2020 deadline. The state therefore anticipated most all settings found to be isolating would need to go through the full heightened scrutiny process including CMS review. When CMS extended the final deadline for states to achieve full compliance to March 17, 2023, CMS also extended this deadline for isolating settings to July 1, 2021. Consequently, all settings identified as isolating, that had a state-approved Transition-to-Compliance-Plan (TTCP) in place with sufficient time to complete remediation by July 1, 2021, were afforded the opportunity to attempt to fully remediate by this deadline in order to avoid the full heightened scrutiny process including the need for an evidentiary package, posting for public comment and CMS review.

While the deadline being moved back one year created a limited opportunity for settings to fully remediate and avoid the full heightened scrutiny process, COVID-19 delays discussed previously had particular impacts on settings identified as isolating. Ultimately, ninety-eight (98) settings determined to be isolating received their findings report with sufficient time to submit and receive approval for a proposed transition-to-compliance-plan (TTCP) that outlined their remediation to be completed by July 1, 2021. Five (5) of these settings were able to fully remediate their isolating qualities and come into full compliance by July 1, 2021. The remaining ninety-three (93) settings, and an additional ninety (90) settings that were determined to be isolating, are required to go through the full heightened scrutiny process.

⁶³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf>

Requirement for Isolating Settings to Submit Evidentiary Package

For any setting, found to be isolating through the state’s setting assessment and validation process, that did not have a state-approved Transition-to-Compliance-Plan (TTCP) in place with sufficient time to complete remediation by July 1, 2021, or that still required additional time to remediate its isolating qualities and/or other areas of non-compliance with the settings standards, a full heightened scrutiny review process is required. To support providers operating these settings in developing and submitting the federally required evidentiary packages (EPs), the state offered training, an EP fillable template, tools and technical assistance to support completion of EPs, and a round of feedback on each initial draft EP submitted by a provider. Training and technical assistance that was offered spanned multiple months. The recorded trainings, fillable EP template and tools to support providers are posted on both the OADS HCBS Training and Resources page (<https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources>) and on the EconSys HCBS Compliance Portal (https://maine.hcbscompliance.com/training_materials). Because the deadline for full remediation of non-compliance for these settings is later than the necessary timeline for EPs to be submitted to the state, and in turn to CMS, the EPs focused on two things:

- Documenting all areas where the assessment and validation process determined the setting compliant; and
- Describing the setting’s commitments and plans for addressing all non-compliance, including remediating its isolating qualities and overcoming the institutional presumption, by the established deadline for all settings to completely remediate and reach full compliance.

As mentioned above, draft EPs submitted are reviewed by the EconSys heightened scrutiny subject matter expert (SME) and feedback is provided to the setting that aids in the preparation of a final draft for formal review by the Executive Steering Committee (ESC). When the final draft EP is received by EconSys, the EP is submitted to the ESC. To date, 84% of settings required to submit an EP have submitted a final draft EP that has been forwarded to the ESC for formal review.

Formal State Review of Each Isolating Setting’s Evidentiary Package

The ESC (appropriate members with relevant expertise), on behalf of the state, does a formal review of the entire EP and makes one of two possible determinations regarding the setting:

- The state believes that the setting **is** capable of overcoming the isolating qualities that make it presumed institutional and **can** come into full compliance with the HCBS Settings Rule by the deadline for all existing settings established in the Global HCBS Waiver Rule, and ultimately be in full compliance and no longer isolating by March 17, 2023. If the ESC makes this determination, the state confirms it will, subject to public

comment, submit the setting to CMS for heightened scrutiny review to seek approval to continue to use the setting for HCBS after March 17, 2023.

- The state believes that the setting **is not** capable of overcoming the isolating qualities that make it presumed institutional and **cannot** come into full compliance with the HCBS Settings Rule by the deadline for all existing settings as noted in this STP, and ultimately be in full compliance and no longer isolating by March 17, 2023. The ESC will only make this determination after giving the provider the opportunity to receive technical assistance and revise their EP based on state feedback outlining specific concerns leading to possibility of this determination being made. If the ESC makes this determination, the state confirms its intent, subject to public comment, not to submit the setting to CMS for heightened scrutiny review to seek approval to continue to use the setting for HCBS after March 17, 2023.

Any settings determined **not** capable of overcoming their isolating qualities go through an additional review and decision-making process involving a broader group of ESC members including leadership from OADS and OMS. To date, one-hundred four (104) settings have been reviewed and all of these settings have been initially determined **capable** of overcoming their isolating qualities.

Posting of Setting Evidentiary Package Summaries for Public Comment

After the state has made its initial determination regarding each isolating setting's ability to overcome its isolating qualities and come into full compliance with the Rule, the state is required to post a summary of the setting's EP, with the state's initial determination, for thirty (30) days. Summaries focus on evidence submitted with regard to the setting's intent and ability to overcome its isolating qualities. These summaries describe to what degree, after the setting has fully implemented its state-approved TTCP, the setting will no longer have the effect of isolating members receiving HCBS from the broader community, including members of the broader community who do not receive HCBS. Postings provide some information about the setting's location without disclosing specifics that would compromise the right to privacy for HCBS members utilizing the setting.

Due to the timing of the posting of this Final STP, the state is posting a portion of isolating settings' EP summaries in Appendix XIII. Summaries included in this Final STP are those for isolating settings that submitted a final draft EP in sufficient time for the ESC to review and make an initial determination, as described above, prior to the posting of this Final STP. Summaries for the remaining isolating settings, that submit final draft EPs for the ESC to review and make an initial determination, will be posted in a separate public comment period planned for September 1-30, 2022.

All isolating settings that did not submit an EP prior to March 9, 2022 were formally notified by OADS on March 10, 2022 that if they choose not to submit an EP to the state, the state will be

unable to make a determination regarding the setting's ability to overcome its isolating qualities and come into full compliance with the Rule and therefore, in the absence of supporting evidence, the state's initial determination must be that the setting **is not** capable of overcoming the isolating qualities that make it presumed institutional and **cannot** come into full compliance with the HCBS Settings Rule by the deadline for pre-March 17, 2014 settings established in the Global HCBS Waiver Rule. As noted above, if the ESC makes this determination, the state confirms its intent, subject to public comment, not to submit the setting to CMS for heightened scrutiny review to seek approval to continue to use the setting for HCBS after March 17, 2023. To date, 89% of settings required to submit an EP have submitted at least a draft EP, including 84% that have submitted a final EP. The State continues to reach out to settings that have not submitted an EP to offer assistance.

Final State Review and Determination for Setting

After receiving public comments, the ESC will take account of public comments and make a final determination for each setting with regard to whether the state concludes the setting can overcome its isolating qualities and come into full compliance with the Rule by the deadline for all existing settings as noted in this STP, and ultimately be in full compliance and no longer isolating by March 17, 2023.

Submission to CMS of Final List of Isolating Settings State is Seeking Approval to Retain for HCBS After March 17, 2023, and After Full Remediation is Completed

If, after considering public comment, the ESC determines the setting can overcome its isolating qualities and come into full compliance with the Rule, the state will include the setting on the list of settings submitted to CMS for heightened scrutiny review. Per the regulation, CMS's determination will be final.

As of the finalization of this STP, the state anticipates submitting up to 146 evidentiary packages to CMS after the second public comment period is completed. It should be noted that some settings determined to require heightened scrutiny (see Table 25 above) are no longer being used for HCBS and thus the state will not be submitting an evidentiary package for these settings.

The state and EconSys will continue to work with the setting to implement remediation as outlined in its approved TTCP while CMS is rendering its decision. For settings which CMS approves through heightened scrutiny review, the state will continue supporting the setting to fully implement its TTCP and come into full compliance. If a setting is not approved by CMS, the state will work with the setting to ensure safe and person-centered relocation of HCBS members to fully compliant alternative settings by no later than March 17, 2023 as described in section titled, [Supporting Participants who Must Relocate to Fully Compliant Settings Before the End of the Transition Period](#) of this plan.

Work Plan and Timeline for Ensuring Compliance

The state has updated the detailed work plan and timeline for executing the various sections outlined in the STP that was included in the initial STP. The updated workplan is located in Appendix VIII. While the workplan remains ambitious, DHHS is confident that with the continued cooperation and partnership with providers, the continued input and meaningful engagement of other stakeholders through the Stakeholder Advisory Committee (SAC) and strong state agency partnerships, the successful implementation of Maine’s statewide transition plan will be realized. This is a critical component of the state’s ongoing systems-change work to assure high-quality HCBS throughout the state.