Community Pathways Waiver

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Requirements concerning the independent audit of provider agencies

In accordance with the Maryland Annotated Code Health-General Article Title 7 and applicable Maryland regulations, DDA providers are required to submit on an annual basis: (1) a cost report documenting the provider's actual expenditures for the fiscal year being reported; (2) audited financial statements supporting the cost report; (3) a worksheet reconciling the cost report to the financial statement; and (4) a certification by an independent certified public accountant, who is not an employee of the licensed provider or any affiliated organization, that they prepared the cost report and financial statement.

(b) and (c) The State's audit strategies performed by various State agencies

1. Single State Audit

There is an annual independent audit of Maryland's Medical Assistance Program ("Medicaid") that includes Medicaid's home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of providers' claims for payment for services. The contract for this audit is bid out every 5 years by Maryland's Comptroller's Office.

2. Office of Legislative Audits

The Maryland Office of Legislative Audits (OLA) conducts fiscal compliance audits every 3 years. The objectives of these audits are to examine financial transactions, records, and internal controls, and to evaluate the State agency's compliance with applicable State laws, rules, and regulations.

3. Office of the Inspector General Health (OIGH)

The Maryland Department of Health's Office of the Inspector General Health conducts audits of the DDA contractual and Waiver services. The objectives of these audits are:

a. Determine the amount of program revenue received and allowable expenditures incurred by the program for the DDA contracts;

b. Determine any amount due to the State or to the provider resulting from the operation of the program during the audit period:

c. Determine to the extent possible that relevant financial matters were conducted in accordance with the Department of Health's Human Services Agreement Manual (HSAM); and,

d. Provider recommendations for improving internal controls, ensuring fiscal compliance, or increased efficiency.

The Office of the Inspector General Health conducts the audits every 3 years. If there have been issues in the past, the Office of the Inspector General Health may audit more frequently.

4. Utilization Review

The DDA has hired a Quality Improvement Organization-like contractor to conduct post-payment utilization reviews of claims to ensure the integrity of payments made for all Medicaid waiver program services. These utilization reviews are to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for were provided to the participant. The reviews will consist of reviewing provider furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the participant's Person-Centered Plan Detailed

Service Authorization (DSA) in LTSSMaryland. This review will apply to both Provider Managed (agency-directed) and Self-Directed Services Delivery Models.

The scope of the post-payment utilization review is limited to a statistically valid sample of claims by service category on an annual basis with a 95% +/-5% confidence interval. The number of providers audited will be based on the sample of participants selected for review. The review period will be 1 year of service.

The Contractor will conduct a remote audit of providers or Financial Management and Counseling Services agencies, requesting and reviewing information, including: staff notes and logs for the consumer(s) identified in the remote audit; the provider's staffing plan, timesheets, training records, qualifications, payroll records and receipts; and any other documentation required by the Maryland Department of Health. The Contractor will prepare an initial findings report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the Person-Centered Plan.

Based on the results of the remote audit, an on-site review might be required to look for systemic claims issues for the provider. The Contractor shall conduct the on-site review based on the presence of the following criteria:

a) Less services provided than billed;

b) Less or more services provided than authorized in Person-Centered Plan (+/- >14%);

c) Services provided did not match the definition of services billed or comply with applicable service requirements;

d) Staff qualifications could not be confirmed in the remote audit or the individual providing service was not appropriately qualified; and

e) Payments that cannot be substantiated by appropriate service record documentation.

No criterion is weighed more than any other. The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than 15 working days from the date of the conclusion of the audit. Based on the findings, the

DDA will prioritize an on-site review based on the prevalence of audit issues.

For the on-site review, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's Person-Centered Plan. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the participant receiving services, and/or the participant's family or legal guardian and Coordinator of Community Services, as appropriate. The DDA may instruct the Contractor to expand the scope of their review based on system issues, such as abuse, and rights issues present in their reported findings.

The major difference between the remote reviews and the on-site reviews is that the on-site reviews require the Contractor to conduct an in-person review and interviews to determine if the service hours and supports match the level and quantity identified in the participant's Person-Centered Plan. The interview will include the participants receiving services, their family or legal guardian, and provider staff, as appropriate.

The Contractor shall prepare a summary of the review findings and will hold an exit interview in-person with the provider and provider staff as appropriate to verbally share a synopsis of their findings. This will be followed ~~up~~ by a formal letter of findings and an opportunity for the provider to provide input.

The Contractor will submit a report of the overall findings of the review for each provider to the DDA Contract Monitor no later than 15 working days from the date of the conclusion of the review. A review report is considered "discrepant" if less than 100% of billed services have been verified. Review reports must include information regarding any fiscal deficiencies between the services awarded and billed, and to services provided to the person. If the review report identifies that less than 86% of the required services were provided, the Regional Office must also review the findings. All reviewed documentation must be maintained and made available to the DDA.

The Contractor handles follow-up of corrective action plans, if any are required. The DDA Fiscal Unit will pursue any financial recovery owed to the State. If necessary, the DDA may also refer the matter to the Maryland Department of Health's Office of the Inspector General Health. The DDA is responsible for overseeing Contractor performance.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. **Sub-Assurances:**

a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Financial Accountability - Performance Measure #1: Percentage of paid claims that are supported by documentation that services were delivered as outlined in the service plan.* *Numerator = number of claims reviewed that are supported by documentation. Denominator = number of claims reviewed.*	
Data Source (Select one) (Several options are listed in the on-line application)*: Other*		
If 'Other' is selected, specify: *Quality Improvement Organization Utilization Review*		
Responsible Party for data	**Frequency of data collection/generation:**	**Sampling Approach (check each that**

collection/generation (check each that applies)	(check each that applies)	applies)
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☒ Other Specify: *Quality Improvement Organization*	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
	☒ Annually	Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☒ Other Specify: *Quality Improvement Organization*	☐ Quarterly
	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	*Financial Accountability - Performance Measure #2: Percentage of paid claims for participants that were eligible on the date of service and met service authorization criteria.* *Numerator = number of paid claims reviewed for participants that were eligible on the date of service and met service authorization criteria.* *Denominator = number of claims reviewed.*
***Data Source (Select one) (Several options are listed in the on-line application)**: Other*	
***If 'Other' is selected, specify:** Quality Improvement Organization Utilization Review*	

Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☒ Other Specify: *Quality Improvement Organization*	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
	☒ Annually	☐ Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	**Frequency of data aggregation and analysis (check each that applies):**
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☒ Other Specify: *Quality Improvement Organization*	☐ Quarterly
	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Financial Accountability - Performance Measure #3: Percentage of paid claims, paid in accordance with the reimbursement methodology.* *Numerator = number of reviewed claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims reviewed.*

Data Source (Select one) (Several options are listed in the on-line application)*: Other*

If 'Other' is selected, specify: *Quality Improvement Organization Utilization Review*

Responsible Party for data collection/generation (check each that applies)	**Frequency of data collection/generation: (check each that applies)**	**Sampling Approach (check each that applies)**
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☒ Other Specify: *Quality Improvement Organization*	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
	☒ Annually	☐ Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	**Frequency of data aggregation and analysis (check each that applies):**
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☒ Other Specify: *Quality Improvement Organization*	☒ Quarterly
	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

PM1 – The Quality Improvement Organization will review a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

PM2 - The reimbursement logic built into the Medicaid Management Information System, Provider Consumer Information System2, and LTSSMaryland will ensure that Waiver program participants are eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, the DDA fiscal staff, or Medicaid. For Provider Consumer Information System2 claims, the DDA fiscal staff will monitor claims activity monthly to identify potential issues with the eligibility information or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into the Medicaid Management Information System, Provider Consumer Information System2, and LTSSMaryland will ensure that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, the DDA fiscal staff or Medicaid. For Provider Consumer Information System2 claims, the DDA fiscal staff will monitor claims activity monthly to identify potential issues with the reimbursement rate.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Performance Measure #1- Number and percentage of paid claims that are supported by documentation that services were delivered as outlined in the service plan.

If the DDA or the Quality Improvement Organization finds provider documentation is insufficient to support a claim, depending on the nature of the issue, additional records will be selected for review by the Quality Improvement Organization, and the Department may initiate an expanded review or audit. If indicated, DDA will work with Provider Services and/or the Quality Improvement Organization to

conduct further claims review and remediation activities as appropriate. The provider may be requested by Provider Services to submit a corrective action plan that will specify the remediation action taken. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, and voiding (and/or recovering) payments, if the situation warrants. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

Performance Measure #2- p*ercentage of paid claims for participants that were eligible on the date of service and met service authorization criteria.*

If a problem is identified, appropriate corrective action will be conducted in a timely manner by the DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with Provider Consumer Information System2 or the *LTSSMaryland* Provider Billing Support *staff* and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, the DDA will adjust the claims accordingly and in a timely manner.

Performance Measure #3- Number and percentage of paid claims, paid in accordance with the reimbursement methodology.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by the DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with Medicaid. Claims entered into the system incorrectly will be corrected and the universe of paid claims that were processed using the incorrect information will be identified. In the rare event that a claim is not coded or paid correctly, the DDA will adjust the claims accordingly and in a timely manner.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
☐ State Medicaid Agency	☐ Weekly

☒ Operating Agency	☐ Monthly
☒ Other Specify: Quality Improvement Organization	☐ Quarterly
	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non- operational.

☐ Yes

☒ No

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability
I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rate methodologies for Waiver Fee Payment System (Fee Payment System) services varied in Waiver Years 1-2 as the DDA transitioned from a prospective payment system to a fee-for-service reimbursement model. Simultaneously the DDA transitioned from the current standalone platform, Provider Consumer Information System2, to the Medicaid Long Term Services and Supports system, or LTSSMaryland. The transition was completed in the first quarter of Waiver Year2.

In Waiver Years 1-2 Fee Payment System services, or those services whose claims were submitted using Provider Consumer Information System2, continued to use rates based on the rate methodology found on page 246 of the Community Pathways Waiver

Application for 1915(c) Home and Community-Based Services Waiver: MD.0023. R06.01 - Jul 01, 2016 found here: https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%20R06%2001%20-%20Effective%20July%201%202016.pdf.

Provider Consumer Information System2 rates were used for: Community Development Services (formerly Community Learning Services), Community Living Group Home Services (formerly Residential Habilitation), Day Habilitation, Employment Discovery & Customization, Career Exploration, and Supported Employment services and ended when billing for these services transitioned into LTSSMaryland at the end of Waiver Year 2. For Provider Consumer Information System2 non-Fee Payment System services, previous rates from the rate study completed November 2017 were revised and trended forward with a 9.5% Consumer Price Index adjustment and were used in Waiver Year 1-2.

The rate methodology for LTSSMaryland services are based on, The Brick Method ™, which is a structure used to develop standard fees for disability services that utilizes cost categories and studies their relationship to direct service support costs, or the wages of people performing the service. The foundation of the Brick is the direct support professional wage derived from the State Occupational Employment and Wage Estimate Bureau of Labor Statistics data.

Included in the rates are 5 standard cost components that are assumed to be common to all social and medical services. They are Employment Related Expenses (ERE), Program Support (PS), Facility Costs (Day Habilitation and Career Exploration-Facility only), Training, and Transportation. Additionally, fee schedule service rates include a 12% General & Administrative (G&A) cost component. A Rate Study Report was released on November 3, 2017 and is published on the DDA's website at https://dda.health.maryland.gov/Pages/Rate_Study_Report.aspx.

A geographically differentiated rate was proposed and adopted for rates in LTSSMaryland as a result of the DDA rate study conducted by JVGA. While the initial report released November 2017 did not recommend a differential, it was later concluded after further analysis that a differential was warranted to account for cost pressures and economic factors impacting certain areas within the State of Maryland.

JVGA recommended, and the DDA concurred, using the Bureau of Labor Statistics' wages for the Washington, D.C. metro Metropolitan Statistical Area to establish a geographic differential rate for Waiver program services as the rates are based on independent wage data.

Payment of the Geographic Differential will be based on the person's residence in Frederick, Montgomery, Prince George's, Calvert, or Charles Counties and is applicable to all Waiver service rates in LTSS*Maryland* except Market Rate services, Behavioral Support Services, Medical Day Care, Environmental Assessment, Family Peer and Mentoring Supports, and Shared Living.

The Waiver includes fee schedule services, market rate services, and tiered rate services. The methods to establish these rates are explained below:

Fee schedule Service Rates (Waiver Years 1-5)

Behavioral Support Services (BSS) - The rates for Behavioral Assessment, Plan and Consulting are based on the Bureau of Labor Statistics hourly wage job code 19-3039 and the rate for Brief Support Implementation Services is based on the Bureau of Labor Statistics hourly wage job code 19-4099. BSS Assessment, Plan, and Consultation service rates include ERE, Program Support, and General & Administrative. The productivity assumption is 12 hours for the Assessment and the Plan. Brief Support Implementation includes ERE, Program Support, Training, and General & Administrative.

Environmental Assessment -The rate is based on the Bureau of Labor Statistics hourly wage job code 29-1122 with a productivity assumption of 6 hours and includes cost components Employment Related Expenses and General & Administrative.

Family and Peer Mentoring - This service is based on a similar service provided in Arizona's Raising Special Kids program and applying Maryland cost values. To calculate the rate for Family and Peer Mentoring, JVGA recommended a wage level based on Bureau of Labor Statistics job descriptions and wage levels for Maryland and used the program support percentage calculated for Targeted Case Management. Since this was a new service without any history, JVGA based the percentage of employment related expenses and general and administrative costs on the Arizona Raising Special Kids

services.

Housing Support Services - The rate is based on the hourly wage Bureau of Labor Statistics job code 21-1012 and includes cost components ERE, Program Support, Training, and General & Administrative.

Medical Day Care – The rate is established by the Medicaid program.

Nursing Support Services – The rate is based on hourly Bureau of Labor Statistics wage data job code 29-1141 and includes Employee Related Expense, Program Support, Training, and General & Administrative.

Respite Care Services (Respite 15-minute unit and Daily) - The rates are based on the Bureau of Labor Statistics wage job code ~~39-9021~~ 31-1120 and includes Employee Related Expense, Program Support, Training, and General & Administrative. The daily rate is based on the 15-minute unit rate with an assumption of 16 hours of services.

Fee Schedule Service Rates (applicable in LTSSMaryland)

Employment Services (Follow-Along Supports and On-going Job Supports) –The rates are based on Bureau of Labor Statistics hourly wage job code 21-1012 and include Employee Related Expense, Program Support, Training, and General & Administrative. On-going Job Supports rate includes a Transportation cost component.

Employment Services (Discovery, Job Development and Customized Self-Employment Services) - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1012. Job Development includes cost components Employee Related Expense, Program Support, Training, Transportation, General & Administrative and a service adjustment to offset general job development activities. Customized Self-Employment includes Employee Related Expense, Program Support, Training, and General & Administrative. The self-employment plan assumes 8 hours of service.

Discovery includes Employee Related Expense, Program Support, Training, Transportation, and General & Administrative. It is a service that assumes 10, 20, and 30 hours to complete each of the 3 milestones levels 1 to 3. Each discovery milestone must be completed as per DDA regulations and policy with evidence of completion of

the required activities before the DDA or the Financial Management and Counseling Services approve them for payment.

Personal Supports- The rate is based on hourly Bureau of Labor Statistics wage job code 21-1093 and includes Employee Related Expense, Program Support, Training, Transportation, and General & Administrative with a service adjustment for no shows and will be billed in 15-minute increments.

Personal Supports Enhanced Supports - The rate is based on Bureau of Labor Statistics wage data job code 21-1093 and includes the cost components Employee Related Expense, Program Support, Training, Transportation, and General & Administrative with a service adjustment for no shows and will be billed in 15-minute increments. Personal Supports 2:1- The rate is twice the rate of Personal Supports Enhanced Supports.

Day Habilitation Services-. The rates for Day Habilitation 1:1 and 2:1 are based on the Bureau of Labor Statistics wage data job code 21-1093 and include cost components ERE, Facility Program Support, Transportation, Training, and General & Administrative. The rates for Day Habilitation Small and Large groups are based on the Bureau of Labor Statistics wage data job code 21-1093 and include cost components Employee Related Expense, Facility, Program Support, Transportation, Training, and General & Administrative as well as a service adjustment.

Dedicated Supports Community Living Group Home 1:1 and 2:1, Dedicated Supports Community Living Enhanced Supports 1:1 and 2:1 and Dedicated Supports Supported Living 1:1 and 2:1 - The rates are based on Bureau of Labor Statistics wage job code 21-1093 and include the cost components Employee Related Expense, Program Support, Transportation, Training and General & Administrative.

Community Development Services - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include Employee Related Expense, Program Support, Training, Transportation, and General & Administrative. The rate for Community Development Group includes a service adjustment. The rate~~s~~ assume~~s~~ staff to participant ratios: 1:1.5, 1:3, and 2:1.

Career Exploration - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program

Support, Training, Transportation, and General & Administrative. The rate assumes staff to ratios of 1:6 for Large Group, 1:3 for Small Group, and 1:3 for Facility. Career Exploration- Facility rate also includes a Facility cost component.

Community Living Group Home Services - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program Support Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-8) and whether overnight supervision is included.

Community Living Enhanced Supports - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components ERE, Program Support, Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.

Supported Living- The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program Support, Training, Transportation, and General & Administrative. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.

Market Rate Services (Waiver Years 1-5)

Assistive Technology and Services, Environmental Modifications, Employment Services Co-Worker Employment, Live-In Caregiver Supports, Remote Support Services, Respite Care Camp, Transition Services, Transportation and Vehicle Modifications, and beginning in Waiver Year 3, Assistive Technology Monthly Service Fees.

Payments for market rate services are based on the specific needs of the participant and the piece of equipment, item or service, type of modifications, or service design and delivery method as documented in the Person-Centered Plan Detailed Service Authorization and Provider Consumer Information System2 as applicable. For needed services identified in the team planning process that do not lend themselves to an hourly rate (e.g., Assistive Technology, Environmental Modifications, etc.), the estimated actual cost, based on the identified need (e.g., a specific piece of equipment)

or historical cost data, is included in the participant's Person-Centered Plan and service authorization budget. The applicable service definitions and limitations included in this Waiver program application may provide additional requirements for payment of these services. The DDA Regional Office fiscal staff review provider invoices to ensure costs for market rate services are authorized on an individual's Person-Centered Plan. The rate study established upper pay limits for these services, except for Assistive Technology. Assistive Technology includes various devices that are driven by market cost. Items that cost more than $2,500 must be recommended by an independent evaluation of the participants' needs. All requests are reviewed and approved by the DDA Regional Offices. The payment limit and any other limiting parameters will be programmed into the Medicaid Management Information System and LTSS*Maryland* to avoid overpayment of these services. Employment Services Co-Worker Employment rate is limited to an upper payment limit. The payment will only be made after DDA or Financial Management and Counseling Services determines with evidence that the required activities have been completed as per DDA regulations and policy.

Family Caregiver Training and Empowerment Services and Participant Education, Training and Advocacy Supports – These services are based on similar services provided in Arizona's Raising Special Kids program. These services do not lend themselves to an hourly rate but are based on the needs of the participant with costs constrained to an upper pay limit or meeting a milestone.

~~Community Living Group Home Services - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program Support Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-8) and whether overnight supervision is included.~~

~~Community Living Enhanced Supports - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components ERE, Program Support, Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.~~

~~Supported Living - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program~~

~~Support, Training, Transportation, and General & Administrative. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.~~

Tiered-Rate Service

Shared Living Services- The three-tiered rates are based on the participant's level of need for supervision and monitoring or the need to mitigate behavioral risk or provide health and safety supports. Formerly a contract service, the tiered rates are based on historical budget amounts that include a stipend, case management, respite care and the application of 12% General & Administrative.

Rates for Self-Directed Services (SDS) Year 1 - 3

Individual and Family Directed Goods and Services, Support Broker Services are available for self-direction only and are negotiated market rates. Participants who are self-directing their services can also establish their own payment rates for approved services in their budgets as they are considered the employer; however, these rates must be reasonable and customary.

To assist participants self-directing their services, the DDA posts reasonable and customary wages and rates in the Self-Directed Services Manual or on the DDA website at https://health.maryland.gov/dda/Pages/sdforms.aspx.

Self-Directed Rates

Participants that self-direct their services, can choose qualified service providers (employees, individual providers (vendor), and DDA providers) for the delivery of paid services. Based on the participant's choice, the applicable new self-directed rates will be used to create the self-directed services funding authorization for each service.

Self-Directed Services - Employee Service Rates (SDS) Year 4 - 5

In Waiver Years 4 and 5, employee self-directed services rates are based on the service Bureau of Labor Statistic wage job code for the service and included cost components.

Self-directed services for which an employee can be hired include Community Development Services Group, 1:1, and 2:1, Employment Services- Follow Along

Supports, Employment Services- On-going Job Supports, Individual and Family Directed Goods and Services Day to Day Administrative Supports, Personal Supports, Personal Support - Enhanced Support, Personal Supports 2:1, Nursing Support Services, Respite Care Services (15 minutes), and Support Broker.

Community Development Services - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include the cost components for Employee Related Expense, Training, Transportation.

Employment Services (Follow-Along Supports and On-going Job Supports) – The rates are based on Bureau of Labor Statistics hourly wage job code 21-1012 and include Employee Related Expense, Training, and Transportation.

Individual and Family Directed Goods and Services Day to Day Administrative Services- The rate is based on the Bureau of Labor Statistic wage job code 43-6014 and includes the Employee Related Expense cost component.

Personal Supports, Personal Support Enhanced, and Personal Supports 2:1 - The rate is based on Bureau of Labor Statistics wage data job code 21-1093 and includes the cost components Employee Related Expense, Training, and Transportation. Personal Supports 2:1- The rate is twice the rate of Personal Supports Enhanced Supports.

Nursing Support Services – The rate is based on hourly Bureau of Labor Statistics wage data job code 29-1141 and includes the Employee Related Expense and Training cost components.

Respite Care Services (Respite 15-minute) - The rate is based on the Bureau of Labor Statistics wage job code 31-1120 includes the Employee Related Expense and Training cost components.

Support Broker Service - The rate is based on the Bureau of Labor Statistic wage job code 13-1071 and includes the Employee Related Expense and Training cost components.

Self-Directed Services - Individual Provider Rates (SDS) Year 1 - 5

As per new State requirement, Nursing Support Services and Support Brokers are designated Individual Providers.
Nursing Support Services and Support Broker services rates are based on the reasonable and customary rates.

Self-Directed Services - Individual Provider Rates (SDS) Year 4 - 5

Self-directed services for which an Individual Provider can be hired include Community Development Services Group, 1:1, and 2:1, Employment Services- Follow Along Supports, Employment Services- On-going Job Supports, Personal Supports, Personal Support - Enhanced Support, Personal Supports 2:1, and Respite Care Services (15 minutes). The rates are based on the Bureau of Labor Statistic wage job code used for the employee's reasonable and customary wages for the service plus a percentage added for self-employment tax.

Self-Directed Services - DDA Provider Service Rates (SDS) Year 4 - 5

DDA providers can be hired for budget authority services. Budget authority services include Assistive Technology and Services; Assistive Technology and Services-Monthly Service Fee; BSS- Behavioral Assessment; BSS- Behavioral Plan; BSS- Behavioral Consultation; BSS-Brief Support Implementation; Community Development Services Group; Community Development Services 1:1; Community Development Services 2:1; Day Habilitation 1:1; Day Habilitation 2:1; Day Habilitation Large Group (6-10); Day Habilitation Small Group (1-5); Supported Living; Dedicated Hours for Supported Living 1:1; Dedicated Hours for Supported Living 2:1; Employment Services Discovery Milestone 1, 2, and 3; Employment Services- Job Development; Employment Services-Co-worker Employment Supports; Employment Services- Follow Along Supports; Employment Services-On-going Job Supports; Employment Services- Customized Self-Employment; Environmental Assessment; Environmental Modification; Family and Peer Mentoring Supports; Family and Caregiver Training and Empowerment; Housing Support Services; Nursing Support Services; Participant Education, Training and Advocacy; Personal Supports; Personal Support Enhanced Support; Personal Support 2:1; Remote Support Services; Live-In Caregiver Supports; Respite Care Services-Camp; Respite Care Services- Day; Respite Care Services 15 minute; Shared Living Levels 1, 2, and 3; Supported Living; Transition Services; Transportation; and Vehicle Modification.

DDA provider rates for Self-Directed Services will mirror DDA provider-managed services rates.

Rate Adjustments

Since rates were initially published, there have been ongoing rate amendments. Prior to FY2016, rates were evaluated for a Cost-of-Living Adjustment. If a Cost-of-Living Adjustment was approved by the Maryland Legislature, the Maryland Department of Health's Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget. Based on the budget allocations, rates may be funded at a percentage of the fully loaded Brick up to 100%. In addition, the geographical differential rates may also be funded at a percentage above the standard rates.

The Maryland General Assembly mandated 4% Cost-of-Living Adjustment was approved for the State FY2020 – FY2024. An additional 8% Cost-of-Living Adjustment was applied to FY2024 rates to be effective January 1, 2024, and a 3% Cost-of-Living Adjustment was added effective July 1, 2024. In Waiver Year 3, the budget includes geographical differential rates of 10% above the standard rate for eligible services.

In April 2021, the DDA increased the Fee Payment System rates in Provider Consumer Information System2 by 5.5% using savings from the American Rescue Plan Act of 2021 for all Home and Community-Based Services waiver services. The 5.5% was calculated by applying 75% of American Rescue Plan Act of 2021 savings towards provider rates as directed by the State legislature.

In February 2022, the Maryland Department of Health started a new rate review process using the Rate Review Advisory Group (RRAG). The new Rate Review process is intended to ensure stakeholders understand the process by which rates are reviewed and feedback is collected, adhere to a structured timeline to support timely rate reviews, enable long-term development and maintenance of DDA rates, allow for stronger consistency in Medicaid rate setting processes, and demonstrate good stewardship of public funds.

Waiver provider rates are available on the DDA website, and service and rate changes

are made through the regulatory process which includes publication in the Maryland Register, Medicaid Transmittal, and a 30-day public comment period as required by law. The last amendment to the rates occurred on or about July 1, 2022. The DDA will continue to review and amend rates as necessary based on the rate setting methodology for comparable services and based on actual costs at least every 3 to 5 years.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The flow of billings for Waiver program services is based on which service delivery model the participant is enrolled in: Provider Managed Services Model or Self-Directed Services Delivery Model.

Electronic Visit Verification (EVV) Requirements

Personal Supports and Respite Care Services are required to be electronically recorded in the Department's Electronic Visit Verification system or approved Financial Management and Counseling Services contractors' Electronic Visit Verification solution. These requirements are related to 42 U.S.C. §1396b(l) and other State and federal laws, regulations, or guidance. The Maryland Department of Health provides an option to exempt Electronic Visit Verification when the services are provided by a live-in caregiver. This applies to both the Provider Managed and Self-Directed Services Delivery Model. The exemption is that live-in caregiver staff do not have to clock in and out in real time.

Billings under the Provider Managed Services Delivery Model

Until the billing for these services transitioned to LTSSMaryland and Electronic Visit Verification for Personal Supports, Respite services and any other Center for Medicare and Medicaid Services required services using Maryland's In-Home Supports Assurance System (ISAS), Day Habilitation Services, Community Development Services, Employment Discovery & Customization, Community Living Group Home Service and Retainer Fees, Supported Employment, and Career Exploration claims were submitted electronically through the DDA's electronic data system called Provider Consumer

Information System2 which interfaces with the Medicaid Management Information System to generate federal claims. Provider Consumer Information System2 data collects information on: (1) the services included in the participant's Person-Centered Plan that can be billed; (2) the approved services and individualized budget set forth in Provider Consumer Information System2; and (3) the services rendered by the provider. Provider Consumer Information System2 authorized services are based on the Person-Centered Plan detailed service authorization. Services rendered are billed against the authorized services in Provider Consumer Information System2 to ensure that overbilling or billing for services not in the Person-Centered Plan does not occur.

In addition, the Medicaid Management Information System has in place a series of coding system "edits" that prevent billing for two or more services that cannot occur at the same time. Claims that are rejected by the Medicaid Management Information System due to system edits are reviewed by the DDA federal billing unit. Based on this review, if the services were rendered in accordance with the Person-Centered Plan the claim will be paid either with State funds only (if not a waiver-covered service), or the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Until the billing for these services transitioned to LTSSMaryland, Assistive Technology and Services, Behavioral Support Services, Environmental Assessments, Environmental Modifications, Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Housing Support Services, Live-In Caregiver Supports, Nursing Services, Participant Education, Training and Advocacy Supports, Remote Support Services, daily and camp Respite Care Services, Shared Living Services, Supported Living Services, Transition Services, Transportation, and Vehicle Modifications were claimed via either a paper billing process using the Center for Medicare and Medicaid Services 1500 Form or direct submission by the provider into the Medicaid Management Information System. The Center for Medicare and Medicaid Services 1500 was completed by the provider of services and submitted to the DDA for review. If the Center for Medicare and Medicaid Services 1500 was consistent with the participant's Person-Centered Plan, then the DDA submitted the claim to Medicaid to be entered into the Medicaid Management Information System. Providers may also directly submit these service claims electronically to the Medicaid Management Information System. Claims that are rejected by the Medicaid Management Information System are reviewed by the DDA federal billing unit.

Based on this review, if the services were rendered in accordance with the Person-Centered Plan, the claim will be paid either with State funds only (if not a waiver-covered service), or the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

When DDA providers fully transition from billing in Provider Consumer Information System and using the manual paper billing process to billing in LTSS*Maryland* and using Electronic Visit Verification for Personal Supports, Respite services and any other Center for Medicare and Medicaid Services required services, providers will electronically bill for all Waiver services for participants based on the services and allowable units in their LTSS*Maryland* Person-Centered Plans Detailed Service Authorization.

The provider submits Medical Day Care claims electronically for payment into the State's eMedicaid system which interfaces with the Medicaid Management Information System to generate federal claims based on allowable units in their plan. Claims that are rejected by the Medicaid Management Information System are reviewed by the provider. Based on this review, if the services were rendered in accordance with DDA's authorization, the claim is corrected and resubmitted. If the services were not actually rendered, then the claim is denied.

Billings under the Self-Directed Services Delivery Model

For participants enrolled in the Self-Directed Services Delivery Model (as described in Appendix E), only the Financial Management and Counseling Services provider can submit claims on behalf of participants self-directing their services. When processing claims on behalf of these participants, the Financial Management and Counseling Services provider compares employee timesheets or invoices against the participant's Person-Centered Plan and annual Self-Directed Services budget, approved by the DDA. For claims that match, the Financial Management and Counseling Services provider then submits them to the Medicaid Management Information System. Claims that are rejected by the Medicaid Management Information System are reviewed by the Financial Management and Counseling Services. Based on this review, if the services were rendered in accordance with DDA's authorization, the claim will be paid either with State funds only (if not a waiver-covered service), or the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is

denied.

Appendix I: Financial Accountability
I-2: Rates, Billing and Claims (2 of 3)

c. ***Certifying Public Expenditures*** *(select one):*

☒	**No. state or local government agencies do not certify expenditures for waiver services.**	
☐	**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**	
	☐	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)
	☐	Certified Public Expenditures (CPE) of Local Government Agencies. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability
I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all Medicaid waiver program services are made through the approved Medicaid Management Information System. The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the Medicaid Office through the Medicaid Management Information System.

a) Verification of Eligibility for a Medicaid Payment on the Date of Service

Medicaid Management Information System edits are in place to validate the participants' waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the Medicaid Management Information System. The FFP claim is based on the review of the paid provider claim by Medicaid. While participant eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information system is updated on a regular basis. The information in the Provider Consumer Information System includes both the authorized service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP.

When billing and claims submission transitions into LTSS*Maryland*, the system will interface with the Medicaid Management Information System to determine participant eligibility before claims are sent. If a participant is determined not to be eligible on a date of service, the claim will not be submitted to Medicaid for payment until eligibility is updated. If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment.

b) Verification that the service was included in the participant's approved service plan

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claim against the Person-Centered Plan Detailed Service Authorization (under the Provider Managed Services Delivery Model), Provider Consumer Information System2 authorization (as applicable) and the Financial Management and Counseling Services verifies the claim against the DDA-approved annual Self-Directed Services budget (under the Self-Directed Services Delivery Model). Please refer to Appendix I-2, subsection b. above for further details about these processes.

When billing for services transitioned into LTSS*Maryland*, providers will only be able to bill for services and units that have been approved and included in the Person-Centered Plans' Detailed Service Authorization.

c) Verification of Service Provision

The participant's CCS performs quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the Person-Centered Plan for participants enrolled in the Provider Managed Services or the DDA-approved annual Self-Directed Services budget for participants enrolled in the Self-Directed Services Delivery Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by the DDA (see Appendix I-1).

If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment. The DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1. Additionally, Electronic Visit Verification was implemented along with LTSSMaryland to verify service provision of Personal Support services, Respite and any other Center for Medicare and Medicaid Services required services.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (select one):

☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

☒ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☒ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For participants enrolled in the SDS Delivery Model (as described in Appendix E), Waiver program services are paid by the Financial Management and Counseling Services provider and then the Financial Management and Counseling Services submit the claim through the Medicaid Management Information System. Providers are informed of the billing process during orientation and training.

The DDA provides oversight of the Financial Management and Counseling Services

providers. The utilization review contractor will conduct reviews. The reviews also monitor and assess the performance of the Financial Management and Counseling Services provider including ensuring the integrity of the financial transactions that they perform.

The utilization review contractor will conduct a remote review of the Financial Management and Counseling Services provider, requesting and reviewing information, including: staff notes and logs for the participants identified in the remote review; training records, the staffing qualifications, timesheets, payroll records and receipts; and any other documentation required by the Maryland Department of Health.

For the utilization review, the scope of the post-payment review is limited to a statistically valid sample of participants and claims by service with a 95% +/-5% confidence interval. The review period will be one year of services.

In addition to the utilization review by the independent contractor, the Department's current contract for the Financial Management and Counseling Services providers includes various requirements that will be overseen by the Maryland Department of Health Financial Management and Counseling Services Program Manager. This includes a variety of monthly reports such as Employee Training Reports, Payroll Reports, Error Reports, Participant Report, and Monthly and Historical Reports. In addition, the contractors will conduct satisfaction surveys and report the results of the surveys to the contract monitor on a quarterly basis.

The Financial Management and Counseling Services provider will be required to submit an annual audit by an independent Certified Public Accountant (CPA) or an independent CPA firm to verify the activities required by the scope of work.

☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

☒ **No. The state does not make supplemental or enhanced payments for waiver services.**

☐ **Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non- Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability I-3: Payment (4 of 7)

d. **Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

☐ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

☒ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Some local Health Departments provide Respite Care services due to a lack of qualified providers in their area to meet the needs of the participants receiving these services.

Appendix I: Financial Accountability I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Complete Appendix I-3-d before completing this section

☒ **The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

☐ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

☐ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

☐ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

☒ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

In Waiver Years 1-2 for Provider Consumer Information System2 services, the payment methodology, outlined in Code of Maryland Regulations, 10.22.17.10-.13, reassignment may be made to the DDA. Conditions for participation from Code of Maryland Regulations 10.09.26.03 require DDA providers to have a provider agreement in effect with the DDA and the Medical Assistance Program.

DDA providers elect to become licensed or approved providers and acknowledge the voluntary reassignment of payments. The DDA has one payment methodology for fee payment services (Residential, Day, Supported Employment, and Personal Supports). Providers agree to accept payments through this methodology.

The DDA provider agreements acknowledge the reassignment of Medicaid payments to the DDA as under the current payment methodology the DDA prospectively pays the providers for expected expenditures for services and the reassignment permits the DDA to recover the outlay for the expenditures. At the end of the first quarter of Waiver Year2, this payment methodology ended when providers began to bill using LTSSMaryland, as they will be paid directly for their services.

ii. **Organized Health Care Delivery System.** Select one:

☐ **No. The state does not employ OHCDS (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

☒ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) A potential provider interested in becoming an Organized Health Care Delivery System provider may apply to do so as part of initial licensure, or by amending their current license, and must meet all regulatory requirements outlined in Code of Maryland Regulations 10.22.20.05. A provider may be designated an Organized Health Care Delivery System provider if they submit a DDA application to become an Organized Health Care Delivery System provider, and they are a licensed DDA provider for a DDA Fee Payment System service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly.

Community agencies and DDA-licensed or certified providers can apply to be an Organized Health Care Delivery System provider. The following services can be provided by an Organized Health Care Delivery System provider:

1. Assistive Technology and Services;
2. Environmental Assessments and Environmental Modifications;
3. Family Caregiver Training and Empowerment Service;
4. Live-in Caregiver Supports;
5. Participant Education, Training and Advocacy Supports;
6. Remote Support Services;
7. Respite Care Services;
8. Transition Services;
9. Transportation Services; and

10. Vehicle Modifications.

b) Other DDA licensed providers may provide services directly and are not required to contract with an Organized Health Care Delivery System provider. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA’s website.

c) The CCS supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an Organized Health Care Delivery System provider, or other qualified providers under the Self-Directed Services Delivery Model. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time.

d) An Organized Health Care Delivery System provider must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. Organized Health Care Delivery System providers shall enter into a subcontract with each provider as per DDA policy. Subcontracts may include the scope, frequency, duration, and cost of services to be provided; documents the qualifications of the provider of service; details service termination procedures; is consistent with the participant’s Person-Centered Plan and is executed by all parties to the contract. The Organized Health Care Delivery System provider is required to maintain a detailed record on the purchase of services from qualified entities or individuals, including invoices.

e) In the Organized Health Care Delivery System provider application, the provider agrees to submit an aggregate annual summary, delineating Organized Health Care Delivery System provider activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individuals serviced by each subcontractor. The report will be due within 60 days of the end of the State fiscal year. As part of the DDA's quality assurance procedures, the Quality Improvement Organization surveys Organized Health Care Delivery System providers for their compliance with

regulatory requirements, including those requirements governing contracts with qualified providers.

For services not billed in LTSSMaryland, billing for Organized Health Care Delivery System provider contract services is completed by submitting an invoice and Center for Medicare and Medicaid Services 1500 Forms or by direct provider electronic submission in the Medicaid Management Information System. In LTSSMaryland, bills will be submitted for the cost of the services based on what is authorized in a person's Person-Centered Plan. The DDA and Medicaid reviews all claims submitted. The DDA will monitor and conduct oversight of the Organized Health Care Delivery System provider by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. **Contracts with MCOs, PIHPs or PAHPs.**

☒ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

☐ **This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of**

health plans that are used and how payments to these plans are made.

☐ **If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.**

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

☒ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2- c:

☐ **Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or,

indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability
I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

☐ **Not Applicable. There are no local government level sources of funds utilized as the non-federal share.**

☒ **Applicable**

Check each that applies:

☒ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

The Maryland Annotated Code, Health-General, §7-705 states that the DDA will use local funds to offset the State's share of support of Day Habilitation and vocational services. The amount of local funds is limited to the amount paid by each jurisdiction in FY 1984. These funds meet the applicable federal requirements.

Each state fiscal year, the DDA invoices all 23 counties and Baltimore City for the amount noted in statute. The jurisdictions pay the state by check or through an interagency transfer. These local funds are credited to the appropriate budget and are applied to the appropriate expenditures.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency

receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability
I-4: Non-Federal Matching Funds (3 of 3)

c. ***Information Concerning Certain Sources of Funds.*** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

☒ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

☐ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability
I-5: Exclusion of Medicaid Payment for Room and Board

a. ***Services Furnished in Residential Settings.*** *Select one:*

☐ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

☒ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. ***Method for Excluding the Cost of Room and Board Furnished in Residential Settings.*** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The cost of room and board from service costs in determining payment rates for Community Living-Group Home and Community Living-Enhanced Supports are excluded. The Medicaid payment does not include either of the following items which the provider is expected to collect from the participant: (1) Room and board; or (2) Any assessed amount of contribution by the participant for the cost of care.

Respite Care Services may be furnished in a residential setting. The rates developed for Respite Care Services were based solely on service costs and exclude costs for room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

☐ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

☒ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Live-In Caregiver Supports is an Organized Health Care Delivery System provider service and the reimbursement method for these services are outlined in section Item I-3-g-ii.

Live-in Caregiver Supports is limited to the cost of rent and cost of food

associated with the live-in caregiver (and not the participant), calculated as follows:

1. The cost of rent, associated with the live-in caregiver, must be calculated as follows:

a. The difference in cost between: (i) a unit sufficient to house the participant only; and (ii) a unit sufficient to house the participant and the live-in caregiver, providing separate bedrooms for each; and

b. The cost must be based on, and not exceed, the Fair Market Rent for the jurisdiction in which the unit is located as determined by the Department of Housing and Urban Development.

2. The cost of food, associated with the live-in caregiver, must be calculated as follows:

a. The cost of food attributable solely to the live-in caregiver; and

b. The cost must be based on, and not exceed, the U.S. Department of Agriculture's Monthly Food Plan Cost at the 2-person moderate plan level.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

☒ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

☐ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. ***Co-Pay Arrangement.***

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. ***Participants Subject to Co-pay Charges for Waiver Services.***

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. ***Co-Payment Requirements.***

iii. ***Cumulative Maximum Charges.***

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. ***Other State Requirement for Cost Sharing.*** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

☒ No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

☐ Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement. *Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:*