

# Community Pathways Waiver

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

- A. The **State of Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of 1915(c) of the Social Security Act.
- B. **Program Title:**  
**Community Pathways Waiver**
- C. **Waiver Number:**MD.0023  
**Original Base Waiver Number:** MD.0023.
- D. **Amendment Number:**
- E. **Proposed Effective Date:** **9/01/26 (New: 10/1/26)**  
**Approved Effective Date:**
- F. **Approved Effective Date of Waiver being Amended:**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

1. Make technical corrections,

2. Implement limit on the total number of hours relatives, guardians, and legally responsible people can be paid to provide services (known as the 60/40 Rule), and

3. Establishment of a new budget methodology for self-directed services to incorporate new reasonable and customary rates from the State Fiscal Year 2027 budget.

Technical Corrections include:

- Alignment of the shared use of dedicated staffing hours with the 30-hour threshold for meaningful day services noted in DDA's policy and billing guidance and in the FY27 budget bill.

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- Update terminology for “vendor” to “individual provider” to ensure federal assurance for qualified Medicaid providers.

## Appendix C – Participant Services

- Updates policy on shared use of dedicated staffing hours, including alignment with the 30-hour threshold for meaningful day services.
- Establishes limits (the 60/40 rule) on the hours worked by relatives, legal guardians, and legally responsible persons to ensure appropriate service delivery and oversight.
- (New : Updates to Individual and Family Directed Goods and Services - Day-to-Day Administrative Supports from the State Fiscal Year 2027 budget.)

## Appendix E – Self-Direction

- Updates the methodology for determining self-directed budgets based on assessed need, the Person-Centered Plan, and new service rates.
- Clarifies individual providers.
- Moves the responsibility of paying the Financial Management and Counseling Services from the participant to DDA.

## Appendix I – Rates

- Implements new self-directed service rates based on Bureau of Labor Statistics wage data and applicable cost components.

## Appendix J – Cost Neutrality

- Updates cost neutrality projections and service utilization estimates for Years 4 and 5 based on rate adjustments and updated utilization data.

### 3. Nature of the Amendment

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- A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

| Component of the Approved Waiver |                                                  | Subsection(s) |
|----------------------------------|--------------------------------------------------|---------------|
| <input type="checkbox"/>         | Waiver Application                               |               |
| <input type="checkbox"/>         | Appendix A – Waiver Administration and Operation |               |
| <input type="checkbox"/>         | Appendix B – Participant Access and Eligibility  |               |

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| Component of the Approved Waiver    |                                                                 | Subsection(s)                 |
|-------------------------------------|-----------------------------------------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> | Appendix C – Participant Services                               | C-1/C-3, C-2 General Services |
|                                     | Appendix D – Participant Centered Service Planning and Delivery |                               |
| <input checked="" type="checkbox"/> | Appendix E – Participant Direction of Services                  | E-1 and 2                     |
|                                     | Appendix F – Participant Rights                                 |                               |
|                                     | Appendix G – Participant Safeguards                             |                               |
|                                     | Appendix H - Quality Improvement Strategy                       |                               |
| <input checked="" type="checkbox"/> | Appendix I – Financial Accountability                           | I-2                           |
| <input checked="" type="checkbox"/> | Appendix J – Cost-Neutrality Demonstration                      | J-1 and 2                     |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

|                                     |                                          |
|-------------------------------------|------------------------------------------|
| <input type="checkbox"/>            | Modify target group(s)                   |
| <input type="checkbox"/>            | Modify Medicaid eligibility              |
| <input type="checkbox"/>            | Add/delete services                      |
| <input checked="" type="checkbox"/> | Revise service specifications            |
| <input type="checkbox"/>            | Revise provider qualifications           |
| <input type="checkbox"/>            | Increase/decrease number of participants |
| <input checked="" type="checkbox"/> | Revise cost neutrality demonstration     |
| <input type="checkbox"/>            | Add participant-direction of services    |
| <input type="checkbox"/>            | Other (specify):                         |
|                                     |                                          |

MAIN

## 1. Request Information (1 of 3)

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. **Program Title** (optional - this title will be used to locate this waiver in the finder)

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C. **Type of Request:** amendment

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**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

☐ 3 Years

☒ 5 Years

**Original Base Waiver Number:** MD.0023

**Draft ID:** MD.012.08.03

D. **Type of Waiver** (select only one):

Regular Waiver

E. **Proposed Effective Date of Waiver being Amended:** ~~09/01/26~~ (New: 10/1/26)

**Approved Effective Date of Waiver being Amended:**

## PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

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☐ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to Subcategories of the hospital level of care:

☐ **Inpatient psychiatric facility for individuals age 21 and** under as provided

in 42

**CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

☐ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR §440.155**

If applicable, specify whether the state additionally limits the waiver to Subcategories of the hospital level of care:

☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

**X Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities.

Select one:

☒ **Not Applicable**

☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates (check each that applies):

- **section 1915(b)(1) (mandated enrollment to managed care)**

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- section 1915(b)(2) (central broker)
- section 1915(b)(3) (employ cost savings to furnish additional services)
- section 1915(b)(4) (selective contracting/limit number of providers)
- section 1915(b)(4) (selective contracting/limit number of providers)
- **A program operated under section 1932(a) of the Act.**  
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

## H. Dual Eligibility for Medicaid and Medicare.

Check if applicable

**X This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

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**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Community Pathways Waiver (CPW) is designed to provide support services to participants and their families, to enable participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans. It supports participants and their families as they focus on life experiences that point the trajectory toward a good quality of life. Services can support integrated life domains that are important to a good quality of life for the participant, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. These services will build on each participant's current support structures to work toward individually defined life outcomes, which focus on developing the participant's abilities for self-determination, community living, socialization, and economic self-sufficiency. The intent of services and supports are to maintain, acquire, and increase individual's independence and reduce their level of services needed.

As an Employment First State, Meaningful Day and Employment services are predicated on the belief that all individuals with developmental disabilities can work when given the opportunity, training and supports that build on an individual's strengths. Employment is the first service considered but not the only choice.

As a Technology First State, our first initiative is to provide information regarding assistive technology resources as the first option of community support. Assistive technology supports and services allows Marylanders with disabilities to enhance their functional independence and support their self-defined goals.

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## Waiver Organizational Structure:

The Maryland Department of Health is the single state agency ultimately responsible for administering Maryland's Medical Assistance Program. The Maryland Department of Health's Office of Long-Term Services and Supports is responsible for ensuring compliance with federal and state laws and regulations in the operation and administration of this and other Waiver programs. The Maryland Department of Health's Developmental Disabilities Administration (DDA) is the operating state agency operating this Waiver program and providing funds for community-based services and supports for eligible individuals with developmental disabilities in the State of Maryland. DDA has a Headquarters and four Regional Offices across the State: Central, Eastern, Southern, and Western.

DDA utilizes various agents, licensed providers, and contractors to support administrative tasks, operations, and direct service delivery. Medicaid State Plan targeted case management services are provided by certified Coordination of Community Services provider organizations. The Maryland Department of Health's Office of Health Care Quality performs licensing, surveys, and incident investigations of many of DDA's licensed home- and community-based services providers. The Maryland Department of Health's Office of Inspector General investigates allegations of overpayment or fraud.

Participants will receive case management services, provided by DDA certified Coordination of Community Services providers, through the Medicaid State Plan targeted case management authority. Each CCS assists participants in developing a PCP, which identifies individual health and safety needs and supports that can meet those needs. The CCS is also responsible for conducting monitoring and follow-up to assess the quality-of-service implementation.

Services are delivered under either the Self-Directed Services or Provider Managed Service Delivery Models provided by qualified providers (such as individuals, community-based service provider organizations, vendors, and other entities) throughout the State. Services are provided based on each participant's PCP, to enhance the participant's and their family's quality of life as identified by the participant and their PCPning team through the PCPning process.

Services are provided by individuals or provider organizations (i.e., private entities and local health departments) that meet applicable requirements in Appendix C prior to rendering services. For Provider Managed Services Delivery Model, individual providers and provider organizations are licensed or certified by the Maryland Department of Health; for the Self-Directed Services Delivery Model, the individual provider or provider organization must be certified or licensed by the Maryland Department of Health and confirmed by the FMCS provider as meeting applicable requirements. Providers offering career exploration, facility-based supports, day habilitation, licensed respite, community living-group home, and community living-enhanced supports waiver services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the participants own home such as employment services, personal supports, respite, and assistive technology and services must meet provider

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qualifications to be certified by DDA. FMCS providers and Support Broker services are also provided for participants that use the Self-Directed Service Delivery Model. This organizational structure provides a coordinated community-based service delivery system so that participants receive appropriate services oriented toward the goal of full integration into their community.

DDA has a contract with an entity that is certified by Centers for Medicare and Medicaid Services as a QIO to:

1. Provide strategies that enhance the quality of life and help to ensure the health and wellbeing for individuals with intellectual and developmental disabilities.
2. Develop audit standards for DDA's services including review cases and analyze patterns of services related to assessed need and quality review.
3. Conduct ongoing utilization reviews to safeguard against unnecessary utilization of care and services and to assure efficiency, economy, and quality of care.
4. Administer DDA's National Core Indicators Surveys.

## Termination of Participation

A participant shall be terminated from enrollment in the Medicaid waiver program if the participant:

1. No longer meets the eligibility requirements;
2. Voluntarily chooses to disenroll from the Medicaid waiver program;
3. Fails to use a CCS;
4. Fails to participate in or otherwise complete any assessments or screenings required by the Department, such as the Health Risk Screening Tool within 30 calendars of the due date;
5. Refuses in-person health, welfare, and service monitoring visits from Coordinators of Community Services and Maryland Department of Health staff without good cause, as determined in DDA's sole discretion;
6. Fails to comply with applicable Medicaid waiver program requirements as set forth in this Medicaid waiver program application, applicable federal and State law and regulations, and Department or Administration policies; or
7. Fails to maintain continuous Medicaid waiver-funded services without a lapse exceeding 183 calendar days, as required by the Waiver application. A minimum of 1 waiver service must be used every 6 months.
8. Dies.

## Waiver Re-Enrollment

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1. If an individual is terminated from enrollment in the Medicaid waiver program, that individual may re-enroll in the Medicaid waiver program if:

- a. The individual meets eligibility requirements; and
- b. The Medicaid waiver program has a slot and funding available to support re-enrollment.

2. An individual may be re-enrolled in the Medicaid waiver program as provided in either:

- a. During the same waiver year;
- b. Within 90 days of termination; or
- c. Subsequent waiver years based on reserved categories and placement on the waiting list.

3. If an individual is not eligible for re-enrollment, then the individual may be placed on the Waiting List if the individual has a developmental disability.

## 3. Components of the Waiver Request

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The waiver application consists of the following components. **Note: Item 3-E must be completed.**

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
  - Yes. This waiver provides participant direction opportunities.** Appendix E is required.
  - No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. **Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the quality improvement strategy for this waiver.

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- I. **Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

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- A. **Comparability.** The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. **Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

☒ **Yes**

- C. **Statewide**ness. Indicate whether the state requests a waiver of the **statewide**ness requirements in section 1902(a)(1) of the Act (*select one*):

☒ **No**

**Yes**

If yes, specify the waiver of statewide

**Geographic Limitation.** A waiver of statewide

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewide

*Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

- A. **Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
  - 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

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2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited

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to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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**Note: Item 6-I must be completed.**

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide

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individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups including but are not limited to employment, self-direction, technology, supporting children and families, person-centered planning, coordination of services, training, system platforms, and rates. These partnerships provide opportunities to obtain additional information, input, and recommendations from participants that can influence services offered by this Waiver program and applicable policies and procedures.

## **WAIVER AMENDMENTS ANNOUNCEMENT AND DEDICATED AMENDMENT WEBSITE**

On April 29, 2026, Medicaid released a public announcement about the proposed waiver amendments. The announcement was posted on the Medicaid Home and Community-Based Services (HCBS) website located at <https://tinyurl.com/ykhf3mdc>.

DDA held a public Community Meeting on May 4, 2026 to share updates on program sustainability, State budget requirements, overview of program changes, and the opening of the public input process.

Notices of Request for Public Comment were posted at the Maryland Department of Health and at local DDA Regional Offices.

Hard copies of the proposal ~~are~~ (New: were) available for public review and comment. Individuals may request a copy by:

- Emailing [wfb.dda@maryland.gov](mailto:wfb.dda@maryland.gov)
- Calling DDA
- Visiting a DDA Regional Office or MDH headquarters

Individuals may also ask their Coordinator of Community Services or service provider for help getting a hard copy.

DDA created a dedicated webpage for the 2026 Community Pathway Medicaid Waiver Amendment with detailed information about the proposed changes.

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Track change documents are available so readers can clearly see what updates are included in the amendment. These documents are provided in both color and black-and-white versions to support accessibility, including compatibility with screen readers.

The dedicated webpage is available here:  
2026 Community Pathway Medicaid Waiver Amendment  
<https://tinyurl.com/45edtn7m>

## AMENDMENT WEBINARS

DDA ~~will host~~ (New: hosted) public webinars to share information about the proposed amendment.

1. Tuesday, May 5, 2026

These sessions ~~will provide~~ (New: provided) a general overview of the proposed changes and question and answer session.

English Webinar: 12:00 - 1:30 p.m.

Spanish Webinar: 3:00 - 4:30 p.m.

2. Tuesday, May 12, 2026, from 6 - 7:30 p.m.

This session ~~will provide~~ (New: provided) a general overview of the proposed changes, and question and answer session.

The webinar presentations and recordings ~~will be~~ (New: were) posted on the DDA YouTube Channel and on the dedicated amendment webpage.

## PUBLIC COMMENT PERIOD

The official public comment period ~~is open~~ (New: was) from **April 29, 2026, through May 28, 2026.**

The Maryland Urban Indian Organization was notified on ~~(insert date)~~ (New: April 29, 2026) about the posting of this application and the start of the public comment period, as part of Tribal Consultation requirements.

### Public Input Summary

~~\*\*\*To be added post comment period\*\*\*~~

(New:

The following is a summary of public comments received on the proposed change included in this amendment. Additional information including a plain language summary of comments is available on the dedicated amendment page. DDA received several recommendations for which further engagement with stakeholders is needed. These recommendations were not accepted for this amendment but may inform future amendments.

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## Appendix C - Community Living – Group Home

Commenters raised concern about participants who receive fewer than 30 hours of meaningful day services and how the threshold change affects their access to residential staffing. Commenters requested clarification on the basis for selecting 30 hours and how the change interacts with participants who have high support needs. One commenter recommended piloting the change beginning September 1, 2026 with full implementation January 1, 2027, to allow the workforce time to prepare. Commenters requested clarification on how the threshold change affects cost neutrality projections in Appendix J.

DDA response: The proposed amendment aligns waiver language with current DDA policy and the Fiscal Year 2027 Budget Bill (SB282), which directs that dedicated hours may support more than one participant only when doing so meets each participant's assessed needs and the participants are retired, transitioning between meaningful day services, recovering from a health condition, or receiving fewer than 30 hours of meaningful day services per week.

The amendment reflects the existing residential rate methodology, which assumes approximately 30 hours per week are supported through meaningful day services. The amendment does not change the ability of a participant to receive additional dedicated staffing support based on individually assessed behavioral, medical, safety, or community integration needs.

The threshold change does not alter cost neutrality assumptions; cost neutrality projections in Appendix J reflect current utilization and expenditure data and are subject to CMS review.

## Appendix C - Individual and Family Directed Goods and Services - Day-to-Day Administrative Supports

Stakeholders expressed concerns that the proposed language for Day-to-Day Administrative Support did not align with the requirements of the Fiscal Year 2027 Budget Bill. Commenters recommended revising the language to include administrative activities identified in State law, such as household management and scheduling, appointment scheduling, money management tasks, and assistance with maintaining benefits. Some stakeholders also requested clarification that these activities require dedicated administrative time.

DDA Response: DDA reviewed the comments and updated the Individual and Family Directed Goods and Services (IFDGS) language in the waiver amendment to align with the requirements of the Fiscal Year 2027 Budget Bill. The revised language reflects the administrative support activities authorized in State law and provides greater consistency between the waiver amendment and legislative requirements.

## Appendix E - Individual Provider

Some commenters opposed this change, characterizing it as a substantive policy change rather than a technical correction that eliminates participant access to community-based organizations, small businesses, home care agencies, and specialized programs currently operating as DDA-approved vendors. Commenters described the risk of immediate service disruption, loss of longstanding provider relationships, behavioral regression, and harm to participants with significant medical, behavioral, and communication needs who

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depend on trusted, established providers. Commenters requested that Office of Health Care Quality licensed Residential Service Agencies be recognized as qualified providers without duplicative DDA licensing requirements, and that a provisional or expedited approval pathway be established, including a 'ramp to licensure' allowing vendors with applications submitted by July 1 to continue providing services while their application is under review. Commenters raised concern that the Electronic Provider Revalidation and Enrollment Portal (ePREP) to Maryland Provider Registration and Information Management Enterprise (MPRIME) system transition creates additional operational barriers for vendors seeking to complete the approval process. Commenters raised concern about disproportionate impact on small, minority-owned, and culturally responsive vendors serving specific communities. Commenters requested clarification on whether small businesses operating as vendors qualify as DDA Individual Providers.

DDA Response: Appendix C outlines qualified providers requirements. The Fiscal Year 2027 Budget Bill (SB282) eliminated the use of unlicensed vendors as a provider type effective July 1, 2026. DDA provided technical assistance for applicants and delayed certain requirements (including MPRIME transition) to support provider readiness and ensure continuity of services. Vendors applying to become a DDA approved provider are not required to enroll in ePREP at this time. MPRIME registration will be required when enrollment becomes available, anticipated in spring 2027. DDA will continue to provide guidance and technical assistance regarding future MPRIME registration requirements.

On June 29, 2026, DDA extended the deadline for certification to August 15, 2026. The purpose is to ensure Medicaid-funded services are delivered by providers meeting applicable federal qualification requirements. The change does not affect providers of allowable goods and services through Individual and Family Directed Goods and Services, which do not require DDA provider enrollment.

Current unlicensed vendors may apply to become qualified DDA providers (individual or agency) and, once approved, may continue providing authorized waiver services. Entities are not required to obtain DDA licensure unless applying to provide Day Habilitation, Career Exploration – Facility Services, or residential services; other vendors must complete the DDA provider application process and receive a DDA Provider Certification Letter and DDA Provider Number.

DDA will continue to provide guidance, technical assistance, and communication regarding provider qualifications, enrollment requirements, and implementation.

Appendix C - Establishes limits (the 60/40 rule) on the hours worked by relatives, legal guardians, and legally responsible person

Some commenters opposed the 60/40 Rule as arbitrary and not based on individualized assessed need, and requested that it be removed from the amendment. Commenters described health and safety risks for participants with complex behavioral, medical, and communication needs who rely on consistent family caregivers and cannot safely transition to unfamiliar staff. Commenters stated the rule undermines the employer authority of self-directing participants to choose their own workers, a foundational principle of self-direction under federal HCBS requirements, and conflicts with Maryland's Self-Direction Act of 2022 (Chapter 737). Commenters requested that any hour limitation apply only to family members who live in the home with the participant, excluding non-resident family members from the cap entirely. Commenters requested that the cap not apply to respite services or to non-primary family caregivers providing time-limited coverage, including in the respite provider's home. Commenters raised concern about the

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application of the cap to in-law relationships and requested that in-laws be excluded from the definition of family. Commenters requested clarification on whether Paid Time Off (PTO) hours count toward the weekly cap and whether the cap applies across all Medicaid programs or only the Community Pathways Waiver. Commenters described significant financial hardship resulting from the combined effect of hour limitations and wage reductions, particularly for caregivers who left outside employment to provide care. Commenters cited another state court ruling related to family caregiver hour limitations and requested DDA review that precedent before implementation. Commenters requested exceptions for emergencies, unplanned staffing departures, and participants with high medical acuity or complex needs who have no available replacement workforce.

Some commenters expressed support for the rule as a program integrity and oversight measure.

## DDA Response

The 60/40 Rule is implemented as required by the Fiscal Year 2027 Budget Bill (SB282), which establishes limits on the number of paid hours that may be provided by legal guardians, relatives, and legally responsible persons under the Community Pathways Waiver. The limitation applies to services provided by legal guardians, relatives, and legally responsible persons and does not change the person-centered planning process, individualized service assessment, or participants' employer authority under the self-directed model within applicable program requirements. Participants who self-direct services continue to retain employer responsibilities, including recruiting, hiring, training, supervising, and dismissing workers.

In response to public comments, DDA will revise the proposed amendment to include an exception for emergencies and unplanned departures of regularly scheduled workers, including inclement weather, sudden illness, unplanned medical leave, sudden loss of an unpaid caregiver, or a worker who unexpectedly quits or is terminated. This exception is intended to protect participant health and welfare and maintain continuity of services during unexpected staffing situations.

DDA will clarify that the limitation applies to Community Pathways Waiver services only and does not apply to services provided through other Medicaid programs. DDA will clarify that approved PTO hours are not counted toward the 40-hour per participant or 60-hour weekly limitation.

DDA will revise the proposed amendment to explicitly include in-law relationships within the definition of relative to promote consistent application of the statutory requirement.

DDA will continue to engage stakeholders regarding implementation, monitor workforce trends, service utilization, and participant outcomes, and evaluate the impact of the limitation on participant access to services and supports.

## Appendix E and I - Self-Directed Service Budget Methodology and Rates

Commenters opposed proposed reductions to self-directed service rates, stating that BLS occupational codes used in the methodology—particularly SOC 21-1093 (Social and Human Service Assistants)—do not reflect the complexity, skill level, or market value of direct support work in self-directed settings. Commenters identified a significant and growing rate differential between self-directed and

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provider-managed service rates and raised concern that this differential creates a structural disincentive to self-direction that may be inconsistent with the expectation of comparable quality under 42 CFR §441.745(a)(1)(ii). Commenters raised concern about the removal of programming and administrative cost components from the self-directed budget methodology and the resulting impact on employee benefits such as PTO and mileage reimbursement, which non-family staff in traditional settings receive through provider agency operations. Commenters requested that participant employer authority and budget authority be explicitly preserved in the revised methodology language, consistent with the Self-Direction Act of 2022 parity requirements. Commenters requested clarification on whether employer authority and budget authority participants will use different rate structures and how payments will be administered through FMCS. Commenters requested that DDA publish the budget methodology formula and provide concrete examples comparing current and projected participant budgets prior to implementation. Commenters requested a delayed implementation date, citing the volume of PCP revisions required and the administrative burden on participants, families, CCS coordinators, and FMCS providers.

DDA Response: The self-directed services budget methodology uses BLS occupational classifications consistent with those used in the provider-managed rate structure while reflecting the distinct cost components applicable to the self-directed service delivery model. The SDS rate methodology includes Direct Support Professional wages, Employment Related Expenses, training, and transportation. Program Support, General and Administrative, and Facility Cost components are not included in SDS rates because participants receive these supports separately through FMCS, Support Broker services, and CCS—supports that are not included in provider-managed rates.

Participants who self-direct services continue to maintain employer authority and may establish wages within applicable reasonable and customary standards and approved budget allocations. The proposed amendment does not eliminate participant employer authority or budget authority. These remain foundational elements of the Self-Directed Service Delivery Model.

In response to public comments, DDA revised the effective date of the self-directed services budget methodology to January 1, 2027, to provide additional time for PCP and budget sheet development, authorization, and processing by participants, families, CCS coordinators, support brokers, and FMCS providers. DDA will continue to provide guidance, technical assistance, and training regarding the revised methodology, implementation requirements, and available supports.

## Appendix E - Financial Management and Counseling Services (FMCS) Fees

Some commenters expressed support for the shift of FMCS costs from participant budgets to DDA, recognizing the benefit of maximizing participant budget funds for direct services. Commenters requested clarification on how the shift will be reflected in Appendix J cost neutrality calculations and whether FMCS costs will be included in Factor D or treated as an administrative cost. Commenters expressed concern about FMCS provider responsiveness and requested that DDA establish a participant help desk and clear guidance for problem resolution during the transition. One commenter proposed implementation of the new budget methodology in January 2027 and another commenter proposed a one year rollout. Comment to explore implementing the methodology change through LTSSMaryland's electronic systems rather than requiring individual PCP revisions for each participant, reducing administrative burden on CCS teams and participants. Commenters requested that participants retain meaningful choice of FMCS providers, with a minimum of three qualified options available, consistent with the Self-Direction Act of 2022.

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DDA response: The change of FMCS payment responsibility to DDA is intended to simplify budget administration for participants and maximize funds available within participant budgets for authorized services and supports. The change does not alter the underlying FMCS service expenditures reported under the waiver. FMCS services will continue to be provided and reimbursed as administrative services, and actual claims expenditures will continue to be reflected in waiver financial reporting and cost neutrality calculations. The payment methodology change does not create a shift in waiver expenditures or cost neutrality assumptions.

Participants who self-direct services retain the right to freely select, change, and evaluate their FMCS provider. FMCS providers remain accountable for supporting participant-directed outcomes. Consistent with the principles of the Self-Direction Act of 2022, participants will be offered no fewer than three qualified FMCS provider options whenever practicable and available.

In response to public comments, DDA revised the effective date of the self-directed services budget methodology to January 1, 2027, providing additional time for FMCS providers and other stakeholders to prepare for implementation. DDA will continue to provide guidance, technical assistance, and communication regarding the transition and available supports for participants, families, support brokers, CCS coordinators, and providers.

## Appendix I - Financial Accountability/Rates

Concerns that individual providers currently working as self-employed vendors could be negatively affected by the proposed changes. They noted that self-employed workers have business expenses, such as self-employment taxes that are not reflected in a standard wage.

DDA Response: In response to public comments related to individuals self-employed providers, DDA will revise the proposed amendment to include rates for individual providers based on the BLS wage job code used for the employee's reasonable and customary wages for the service plus a percentage added for self-employment tax.

## Appendix J - Cost Neutrality

Commenters raised concern that cost neutrality projections are based on paid claims data rather than actual participant need, arguing that claims data systematically underestimates need for participants who could not access services due to workforce shortages or other barriers. Commenters questioned whether the Factor G methodology change—from CMS 372(S) reports to Hilltop Institute analysis of paid claims data—was approved by CMS and independently validated. Commenters questioned whether cost neutrality is achieved through constrained service access and policy-driven cost controls embedded in utilization projections rather than through genuine efficiency. Commenters requested independent third-party validation of the cost neutrality methodology, underlying data sets, and rate assumptions. Commenters noted the narrowing margin between Factor D and Factor G across waiver years and requested sensitivity analysis demonstrating the margin's resilience under multiple scenarios. Commenters requested that all costs of serving people in state institutions be fully incorporated in the comparison, including capital costs of institutional expansion. Commenters requested that all rate and wage data underlying cost neutrality

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projections be published before CMS submission and that the public comment period be extended to allow meaningful evaluation of the financial methodology.

DDA Response: Cost neutrality is a federal requirement for HCBS waiver programs. Cost neutrality projections are intended to estimate aggregate waiver expenditures for federal reporting and oversight purposes and do not determine individual service authorizations, establish service limits, or replace the person-centered planning process.

DDA follows CMS guidance in developing projections using historical cost and utilization data. DDA engaged the Hilltop Institute to review actual Medicaid claims and utilization data and update cost factors for the previous amendment. DDA revised its institutional cost methodology to use actual ICF/IID stays and Medicaid expenditure data, providing a more accurate comparison between Medicaid-funded waiver and institutional services. This revision excludes services funded entirely with State funds, as cost neutrality is based on a comparison of Medicaid-funded expenditures. CMS reviewed and approved the updated cost neutrality methodology.

DDA provided proposed waiver amendment documents, track-change versions, supporting appendices, and related materials for public review during the public comment period, along with public webinars and stakeholder engagement activities that exceeded federal public notice requirements. DDA will continue to monitor actual expenditures, utilization, and cost neutrality performance and work with CMS and partners to ensure projections remain accurate and consistent with federal requirements.)

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services.

## Attachments

### Attachment #1: Transition Plan

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Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

## **Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

**Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.**

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver*

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*settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The State assures this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

## **Additional Needed Information (Optional)**

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*Provide additional needed information for the waiver (optional):*

Proposal