Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

The Maryland Department of Health – Office of Health Services (OHS) and Developmental Disabilities Administration (DDA)

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Community Pathways waiver renewal application enhances services and supports for individuals and families; updates provider and staff qualification standards with national standards; reflects new rates and payment methods; and provides new opportunities for participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans.

The Community Pathways Waiver renewal application includes (1) the introduction of new services; (2) revisions to service descriptions, requirements, limitations, and provider qualifications; (3) transition of some supports to another or new waiver services; (4) transition to new units, rates, and payment methodology (e.g. daily to hourly, monthly, and milestones); and (5) revisions to self-directed services covered under the employer and budget authorities as noted below. Some new services and changes to existing services will be available and in effect July 2018; some will transition during the first year; and others will be implemented July 2019.

The waiver includes the following new services: Employment Services; Career Exploration; Family and Peer Mentoring Supports; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote Monitoring; and three new Nursing Services.

Payment systems will transition to Maryland's Long Term Services and Supports (LTSS) system on July 1, 2019. New service units and rates will be implemented July 1, 2018, unless otherwise noted below.

SERVICE ENHANCEMENTS AND TRANSITIONS - MEANINGFUL DAY SERVICES

Meaningful Day services include: Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation. A participant's Person-Centered Plan may include a mix of Meaningful Day services as provided on different days for the first waiver year. Beginning July 2019, these services will be provided on an hourly basis providing new opportunities and flexibility for participants to receive various Meaningful Day services to meet their individualized goals on the same day. Participants will continue to have access to current professional services (e.g. nursing and behavioral supports) being provided until they transition during the first year to the specific stand alone services. Meaningful Day services with the exception of Supported Employment and Employment Services are limited to 40 hours per week. Participants also have access to various support services including Personal Supports, Assistive Technology and others to meet additional service needs as further noted in Appendix C. Additional details are noted in Attachment A.

SERVICE ENHANCEMENTS AND TRANSITIONS - RESIDENTIAL SERVICES

Residential Services include: Community Living-Group Home, Community Living – Enhanced Supports, Shared Living, and a new Supported Living service to be implemented in July 2019. Additional details are noted in Attachment A.

SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES

Support Services include: Assistive Technology and Services, Behavioral Support Services, Environmental Assessment, Environmental Modifications, new Family and Peer Mentoring Supports, Family Caregiver Training and Empowerment, Housing Support Services, Live-in Caregiver Supports, Nurse Consultation, Nurse Health Case Management, Nurse Case Management and Delegation Services, Participant Education, Training, and Advocacy Supports, Personal Supports, Remote Support Services, Respite Care Services, Transportation, and Vehicle Modifications. Additional details are noted in Attachment A.

SELF DIRECTION

Participants or their legal guardian have the option to choose the self-directed service delivery model. Adult participants can independently self-direct their services or choose a "designated representative". A designated representative is a person authorized by the participant, on the form provided by the Department, to serve as a representative in connection with the provision of services or supports under the self-directed services delivery model. Participants choosing to use the self-directed service delivery model will continue to have access and support from Advocacy Specialists, Coordinators of Community Services, Support Brokers, and Fiscal Management Services. Participants can exercise employer or budget authorities on various services. Employer authority means the participant has decision making authority over staff that provide specific services. The participant is the common law employer. Budget

authority means the participant has decision making authority over their self-directed service budget. Additional details are noted in Attachment A.

1. Request Information

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §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*): **Community Pathways Waiver**

C. Type of Request: *(the system will automatically populate new, amendment, or renewal)*

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
X	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
☐	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)	07/01/2018	

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

○	**Model Waiver**
◉	**Regular Waiver**

E. Proposed Effective Date: July 1, 2018

Approved Effective Date *(CMS Use):*

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)*	
	○	**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 under age 21 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 nursing facility level of care:
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☑	**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 facility level of care:	

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 §1915(a)(1)(a) of the Act and described in Appendix I**		
	☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*		
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to	☐	§1915(b)(3) (employ cost savings

		managed care)		to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §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:*			
☐	**A program authorized under §1915(i) of the Act.**			
☐	**A program authorized under §1915(j) of the Act.**			
☐	**A program authorized under §1115 of the Act.** Specify the program:			

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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 is designed to provide support services to individuals 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 individuals and families as they focus on life experiences that point the trajectory toward a good quality of life across the lifespan. Services can support integrated life domains that are important to a good quality of life, 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 goals for the Community Pathways Waiver include:

- Innovative service options aimed at providing supports that build on the DDA's existing Community of Practice related to Employment and Supporting Families;
- Participant and family self-direction opportunities;
- New Supported Living and housing support services to increase independent living opportunities; and
- Transitioning to new Employment Services and provider rates.

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. Services shall increase individual independence and reduce level of service needed.

Participants will receive case management services, provided by licensed Coordination of Community Services (CCS) providers, through the Medicaid State Plan Targeted Case Management (TCM) authority. Each Coordinator of Community Services assists participants in developing a Person-Centered Plan, ensuring individual health and safety needs are met and services are actually provided, and assuring that participants are satisfied with the services they are receiving.

Services are delivered under either the Self-Directed or Traditional Service Delivery Models provided by qualified providers (i.e. individuals, community-based service agencies, vendors and entities) throughout the State. Services are provided based on each waiver participant's Person-Centered Plan to enhance the participant's and his/her family's quality of life as identified by the participant and his/her family through the person-centered planning process.

3. Components of the Waiver Request

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.

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

A. Comparability. The State requests a waiver of the requirements contained in §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 §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. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

⊙	**No**
○	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

	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 statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *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

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;

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 §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 Improvement Act of 2004 (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 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

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 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 throughout the application and in **Appendix H**.

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

The DDA hired independent consultants, which conducted listening sessions in 2014 on DDA's behalf. In these listening sessions families expressed interest in gaining access to nimble, responsive, and flexible supports for children and adults with developmental disabilities.

The DDA developed this waiver application based on input from: (1) individuals, families, advocates, and community-based services agencies; (2) Self-Directed Advocacy Network; (3) the Family Supports and Community Supports Waivers; (4) the Developmental Disabilities Coalition ("DD Coalition"), which is composed of leaders from the Maryland's Developmental Disabilities Council, Maryland's Protection and Advocacy Agency, People on the Go of Maryland (a self-advocate led organization), Maryland Association of Community Services (the largest community-based service agencies association in Maryland), and the Arc of Maryland; (5) independent consultants; (6) national research; and (7) submitted public comments.

The DDA established a dedicated Community Pathways Waiver webpage and posted information about the program's goals, draft waiver application, and the public webinar presentation. The website is located at:
https://dda.health.maryland.gov/Pages/Community_Pathways_Waiver_Renewal_2018.aspx

The DDA held a two day symposium on May 15 and 16, 2017 to share revised service proposals for the Community Pathways Waiver renewal. During the symposium, participants shared suggestions, recommendations, concerns, and also asked questions.

The DDA conducted information sessions on September 18th, 19th, 20th, or 27th, 2017, where information about the service descriptions was shared. During these events, the DDA answered questions related to changes made.

The Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on November 13, 2017 of the posting of the Waiver application.

On November 13, 2017, t~~T~~he DDA sent out information to all stakeholders and partners regarding the Waiver application posting and request for public comment on November 13, 2017. The website is located at: https://dda.health.maryland.gov/Pages/Community_Pathways_Waiver_Renewal_2018.aspx Request for public input was also posted in the Maryland Register (Issue Date: November 13, 2017), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices. The Public Comment Period was held from November 13, 2017 – December 12, 2017.

The official 30 day Public Comment Period was held from November 13, 2017-December 12, 2017. In total, DDA received 135 responses from families, providers, and advocacy agencies. Below is the summary of the specific recommendations from the public and responses:

The DDA received four comments regarding changes to the Purpose of the HCBS Program. Two comments were related to provider quality, compliance and effectiveness of services delivered to participants and one was related to the evaluation of capacity to self-direct. The DDA accepted the comments and responded that providers will be assessed using performance measure standards, utilization reviews, surveys, and a Quality Improvement Organization. The comment to update Attachment #2: Home and Community-Based Settings Waiver Transition Plan was not accepted. DDA responded that the State is required to include the details related to the Statewide Transition Plan (STP) for Compliance with Home and Community-Based Setting Rule on the plan that was initially approved from CMS.

Two comments were received regarding Appendix A. The DDA clarified that "deemed status" is not needed for Community Residential Habilitation. The DDA did not accept a comment related to only DDA providers reporting issues of participant abuse, neglect, or exploitation.

Four comments were received regarding changes to Appendix B. The DDA accepted two comments related to level of care. The DDA received one comment that reserved capacity for Transitioning Youth was not high enough. DDA explained that additional capacity can be requested if needed.

The DDA received eight general comments about changes to Appendix C. Two comments were accepted related to flexibility around alternative resource documentation and self-direction staff criteria. One comment related to simplifying and combining services needed clarification. The DDA clarified that service description, scope, and standards language were enhanced to better clarify the purpose and provide participants the flexibility to receive multiple services throughout the day. The DDA did not accept comments regarding adding new services - "in lieu of day" and "self-employment". The DDA explained that supports are available through the waiver to support participants' needs. Comments regarding language changes about transportation provisions, exhausting available and appropriate funding sources, and avoiding institutionalization were not

accepted. The DDA explained that language is necessary for waiver submission.

A continuation of the summary of public comments and responses can be found in the Main Module Section B, entitled Additional Needed Information (Optional) section.

The following information is noted in the waiver application found in the Main Module Section B, entitled Additional Needed Information (Optional) section due to template constraints. It is noted here for ease of the reader.

The DDA received four comments regarding changes to Assistive Technology (AT) and Services. One comment was accepted. One comment related to the cap resulting AT requests that do not best suit the participant's needs. DDA explained that individuals and families are encouraged to have an AT assessment to determine the best AT device or item to meet their needs regardless of the cost. One comment to expand the service definition to include information and communication technologies (ICTs). DDA responded the description includes general types of technology support to address a need identified in the PCP and noted in the assistive technology assessment. One comment that certification requirements should not apply if basic assistance is being provided. The DDA explained that provider requirements were based on the recommendations of professionals in the Assistive Technology field, and will not change.

13 comments were received regarding changes to Behavioral Support Services (BSS). The DDA accepted comments related to settings the service can be provided, and non-employment requirements should be removed from BSS Vendor/contractor criteria. The DDA did not accept comments related to removing criminal background check requirements, explaining concern for participants' safety. The DDA provided clarity for a comment regarding no additional certifications for staff of self-direction participants. Participants self-directing services can hire their own staff who must meet minimum qualifications or use a DDA-approved professional or agency or a DDA licensed agency. The DDA responded to a comment that providers must review the PCP and Support Intensity Scale (SIS), by explaining that providers have "complete necessary pre/in-service training based on the Person-Centered Plan". One comment to combine all Behavior services. The DDA clarified that all services were combined prior to the public comment period. The DDA responded to a comment related to the service occurring at the same time as Community Living-Enhanced Supports, stating that staff that would be performing the same scope of behavioral support services within Community Living - Enhanced Supports. The DDA received a comment to clarify that Brief Support Implementation Services (BSIS) is performed by staff supplied by the Behavioral Support Vendor/Contractor or hired by Self-Directed Services (SDS) participant. The DDA explained that BSIS can only be provided by a DDA--approved professional or DDA-approved agency. The DDA did not accept comments that Behavioral Support Services provider requirements be expanded, stating that outlined requirements would remain. One comment related to regular SDS staff not attending Behavioral Principles and Strategies (BPS) training was not accepted. Federal requirements ensure the State establishes essential minimum provider qualifications and that requirements are met when the service is provided. The DDA did not accept a comment to add "unless otherwise approved by DDA." for BSIS, as it is a time-limited service to provide direct assistance and modeling to families, agency staff, and caregivers so they can independently implement the Behavior Plans.

The DDA received 14 comments related to Community Development Services. Two comments were accepted. The DDA responded to a comment about staff training around money and time management, explaining that topic areas were included in basic staff training requirements. One comment related to hour flexibility in the service funding plan. The DDA explained that there is flexibility for participants to choose among several Meaningful Day services during the week. One comment that self-directed services were not considered. The DDA responded that a mix of services

can be provided on the same day for both service delivery models. The DDA did not accept comments to remove the four person limit, stating that the limit is based on national best practices related to community-based non-work day services. One comment to add "meeting new people, making friends, and going to classes or activities for fun, fitness, or to learn." to the definition was not accepted. CDS provides the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities. One comment to allow for a funding to pay for the costs associated with staff attendance for outings. The DDA did not accept, stating that various community activities, resources, and entities that support, or do not require fees for staff to support individuals with disabilities. The DDA did not accept a comment to remove the requirement for activities to be with people without disabilities. CDS helps participants with the development and maintenance of skills related to community membership through engagement in community based activities with people without disabilities. One comment to remove an individualized schedule was not accepted. The DDA responded the schedule is needed to provide an estimate of what the individual will do and where/when the individual will spend his/her time when in this service. One comment to include volunteering in the service was not accepted, as it was indicated in the service definition. A comment to add "Supports within the participant's residence related to community participation, such as participating in social media, playing games, and self-employment cottage industry pursuits." was not accepted, as this service is designed to facilitate community engagement. The DDA did not accept a comment to remove limit requirements.

The DDA received two comments regarding language changes to the Community Living-Group Home definition. One comment to add "physical or mental health and safety" was accepted. The DDA did not accept language regarding service criteria for this service, stating that current the proposed criteria gives clarity, transparency, and specificity.

Seven comments were received regarding Day Habilitation. Two comments were accepted. The DDA did not accept a comment to add "meeting new people, making friends, and going to classes or activities for fun, fitness, or to learn." to the definition. Day Habilitation services provide the participant with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization. One comment to substitute part of the definition with that of the CMS 2015 Technical Guide. The DDA did not accept, stating the current definition gives clarity, transparency, and specificity. One comment to remove D from service definition. The DDA explained from July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant's PCP may include a mix of employment and day related waiver services provided on different days. One comment that employment supports should be added to the service. The DDA did not accept, stating per federal requirements, supported employment supports "do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

The DDA received two comments regarding Employment Discovery and Customization. One comment was accepted. The DDA did not accept a comment related to the time limit of EDC, explaining that EDC activities should be completed within a six month period unless otherwise authorized by the DDA.

12 comments were received related to Employment Services. The DDA accepted a comment to change language about the fading plan of Ongoing Job Supports. The DDA provided clarification for three comments about the Ongoing Job Supports definition, home visits during Discovery, and include tasks needed to maintain a job. The DDA responded that Ongoing Job Supports was defined, face to face home visits help lay the groundwork for a successful Discovery process, and that maintenance tasks are included under job coaching. One comment demonstrated competencies associated with the outcomes instead of certificates was not accepted. Staffing requirements are

designed to ensure that participants receive quality service/support in reaching their goals. The DDA did not accept a comment to allow for Follow Along Supports and stand alone Transportation to be used at the same time, as it is included in the rate for Employment Supports. A comment that only supervisory employment staff be required to obtain DDA approved certification was not accepted. Direct support professionals performing the discovery service need to be appropriately trained and qualified. The DDA did not accept a comment to remove Transportation and Behavioral Supports from the group that cannot be provided at the same time as Employment Supports, as the services are included in the service and rate. A comment that Employer authority needs to be checked for this service was not accepted. One comment to include self-employment in Ongoing Job Supports was not accepted. The DDA responded that Ongoing Job Supports are available to participants that are self-employed, however supports to manage the business like record keeping, billing, etc. are not included. A comment that DDA approved certification in employment should not apply to SDS. The DDA did not accept, stating that individuals performing this service need to be appropriately trained and qualified. A comment that Transportation should be a stand-alone service for SDS participants was not accepted, as transportation is a cost component of this service.

The DDA received one Environmental Assessment comment. The comment to use Minnesota's criteria for providers was not accepted.

The DDA did not accept the two comments related to Environmental Modifications. One comment that home modifications providers do not have to become enrolled waiver providers. The DDA explained that DDA approved professional requirements include to be a licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor. DDA Organized Health Care Delivery System providers can employ or contract with licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor. A comment that family members and relatives should be allowed to provide the service. The DDA responded that relatives and legal guardians are not options to eliminate conflict of interest and ensure that participants health and safety needs are met.

11 comments were received regarding Individual and Family Directed Goods and Services. The DDA did not accept any comments related to the service cap. The DDA explained that the cap was increased to $5,500. IFDGS is an option in which participants can use their individual budget for "permissible purchases" to the extent that expenditures would otherwise be made for the human assistance. One of the federal criteria for IDFGS are able to be accommodated within the participant's budget without compromising the participant's health or safety. A comment to exercise and personal training to allowed categories. The DDA did not accept, as fitness memberships and fitness items purchased at most retail stores are covered through this service. Participants can consider using their personal funds to acquire a professional health trainer/coach or participate in classes and activities. One comment to cooking/meal preparation, computer skills, performing and creative arts. The DDA did not accept; these activities can be supported in Personal Supports and Meaningful Day services. One comment to add post-secondary classes was not accepted, as tuition or educational services are not covered. A comment to allow Therapeutic Services was not accepted. DDA responded that medically necessary therapies recommended by professional clinicians are covered under Medicaid. Therapeutic swimming and therapeutic horseback riding are allowable services. A comment to include fees associated with telecommunications, internet fees, cell and landline, telephone purchase and services. The DDA responded that participants can consider using their personal funds to acquire these services. Comments to include staff expenses to accompany an individual on recreational activities or vacation. The DDA did not accept, stating as per federal instructions, services that are diversional/recreational in nature fall outside the scope of §1915(c) of the Act. There are various community activities, resources, and entities that support or do not require fees for staff to support individuals with disabilities. Comments to include staff bonuses and housing subsidies were not accepted, as the Waiver does not support staff bonuses. 42 CFR §441.310(a)(2) prohibits making Medicaid payments for room and board except when the participant is receiving

respite outside his/her private residence in a facility approved by the State or under Live-in Caregiver Supports. A comment that a request should not be linked to an assessed need was not accepted.

Comments were received related to how caregiver rent was calculated for Live-In Caregiver Supports. The DDA received input from the Maryland Department of Disabilities and consultants related to the method used for calculating caregiver rent. The DDA has established a Housing workgroup and will refer these comments to them for consideration.

The DDA received three comments regarding Nursing Services. The DDA accepted a comment to remove the relative, legal guardian or legally responsible person restriction from being paid for Nurse Case Management and Delegation Services. Relatives can provide the service if they meet the qualifications and authorized by DDA due to the unique needs of the participant and skills of the relative. A comment that nurses consider the participant's individual assessment, PCP, goals, preferences and ability to understand the risks and benefits of health services, and respect their informed choices. The DDA clarified all services offered are designed to respect the participant's informed choice and ensure that participants needs and goals are met, as outlined in the PCP. A comment to combine all nursing services into one was not accepted. The DDA responded that each nursing service is distinct to ensure that the needs of waiver participants are being appropriately addressed.

The DDA received one comment to include lodging and meals as part of Participant Education, Training, and Advocacy Supports. It was not accepted, as CMS denied the request to cover lodging and meals in the Community Supports Waiver.

12 comments were received regarding Personal Supports. The DDA accepted three comments. One comment to add banking and maintaining personal room or living space received clarification. The DDA explained that current language includes these activities. One comment to ensure adequate funding for transportation was referred to the Rate Study conducted by JVGA. One comment that a Retainer Fee was not included was not accepted. The DDA responded that participant self-directed services have the option to provide benefits such as leave for these situations.The DDA did not accept a comment to Personal Supports and Supported Living should be combined. The DDA responded that Personal Supports is designed to assists participants in becoming more independent through developing in home skills and community integration and engagement skills. Personal Supports is limited to up to 82 hours per week and can be provided in the participant's home or their family's home. Supported Living allows for similar supports for up to 24 hours per day in their own home or apartment. A comment to allow for funding to pay for the costs associated with staff attendance. The DDA did not accept, stating there are various community activities, resources, and entities that support or do not require fees for staff to support individuals with disabilities. One comment that Service Requirement H related to transportation being included in the cost should apply only to the traditional service delivery model. The DDA did not accept, as Transportation will be a cost component of this service. A comment to add "but are not limited to" to Service Definition D was not accepted, as CMS advised not to use this language. One comment to remove the requirement for services being available before and after Meaningful Day services. The DDA did not accept, stating that the language used gives clarity, transparency, and specificity. One comment to add "For individuals not self-directing their services," to Personal Support services' limit to 82 hours per week was not accepted. The DDA responded the State may establish a dollar or other limit on a service and provide alternatives once the limit is reached. Supported Living services includes up to 24 hours of service as an alternative to meet needs.

The DDA received 11 comments regarding Remote Monitoring. Six comments related to changing the service title, checking self-directed, ensuring cost neutrality, redefining the provider, and changing language in the service definition. The DDA provided clarity for a comment about

increasing the service cap, stating the limit will be removed and policy developed to reflect services should be implemented in a cost neutral manner. A comment to ensure service will not infringe on a person's civil rights. The DDA responded that each individual living in the residence, his or her legal guardian(s), and teams must be made aware of both the benefits and risks. The service design and implementation must ensure the need for independence and privacy of the participant who receives services in his/her own home. The DDA did not accept a comment to include learning and skills training through live two-way video conferencing, stating the service provides oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs. A comment to include remote/tele supports and allow the service to provided in other public and private community-based settings was not accepted.

The DDA received three comments regarding Respite Care Services. One comment that neighbors and friends should be treated like any other employee. The DDA responded the intent of the language was for the PCP to reflect the use of a neighbor or friends was based on the meeting the safeguard criteria. A comment that respite provided in a private home must be licensed not be required for self-directing participants. The DDA clarified that Respite can be provided in a variety of settings including the participant's home, the home of a relative, friend or neighbor, and a DDA licensed group home. The DDA did not accept a comment to add "For individuals not self-directing their services, …." to "Services can be provided at an hourly rate for 8 hours or less; or at the day rate for over 8 hours, daily." The DDA stated guidance regarding reasonable and customary hourly and daily rates for SDS will be provided.

Seven comments were received regarding Shared Living. One comment to allow respite for participants in this service was accepted. One comment that ongoing supports should not be needed by an agency other than the general oversight provided by the team. The DDA responded that current ongoing supports are being transitioned to stand alone services. A comment that Host Family should also have a one-person environment/home was accepted. Comments that family members serve as shared living staff was not accepted. The DDA responded that this service is provided by a DDA approved provider and for participants who do not have family or relative supports. A comment that this service be self-directed was not accepted. The DDA did not accept a comment that Host Home should not be required to be located through an agency. The DDA responded the service is provided by a DDA-approved provider and includes matching of the participant and the host home based on the participant's preferences. Identification of the host home can come from various sources including homes identified by the participant.

The DDA received three comments regarding Supported Employment. A comment to add self-employment was accepted. A comment to include DDA's commitment to Supported Employment for those needing ongoing staffing support. The DDA explained that Ongoing Supports is included in the definition. The DDA did not accept a comment that Transportation should be a stand alone service for SDS, as Transportation is a cost component of this service. Participants' self-directing services can indicate mileage reimbursement for their staff under benefits.

The DDA did not accept one comment that Transition services could be used to move to your own home from the participant's family home. The DDA explained this service's purpose is to support people transitioning from an institution or most restrictive environment to their own home.

Seven comments were received regarding Transportation. The DDA accepted a comment about training and documentation requirements for providers.

Comments regarding intent of the service and to increase the funding limit. The DDA explained that participants can use their personal funds to pay for transportation expenses. A comment that Service

Requirement G should apply to self-direction services was not accepted, as Transportation is a cost component of this service. Participants' self-directing service can indicate mileage reimbursement for their staff under benefits. A comment to clarify this service is for any transportation need including out of state travel, identified in the plan. The DDA did not accept, stating Transportation services are designed specifically to improve the participant's ability to access community activities within their own community. Transportation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Personal Supports (beginning July 1, 2019), Respite Care, Shared Living, Supported Employment, or Supported Living services as it is a component of these services. A comment to add legal guardian and legally responsible person as an allowable provider under self-direction was not accepted.

The DDA received a comment that a prescription for vehicle modifications should not apply to modifications related to passenger needs. It was not accepted, as the prescription is specific to the year/make/model of the vehicle modification and must be completed by a qualified specialist.

Four comments were received regarding relatives performing services. The DDA accepted two comments related to stakeholder input. One comment to define legally responsible persons criteria for minor children and adults. The DDA explained that similar language is in the waiver application. One comment that relatives who meet provider requirements should be able to provide that waiver service. The DDA did not accept this comment, stating that provider qualifications ensure appropriately certified, trained, and qualified providers deliver services. To eliminate conflict of interest and ensure that participants' health and safety needs are met, relatives and legal guardians are not an option for these services.

The DDA received four comments regarding provider requirements. Comments related to "one size fits all" provider requirements and using the correct name for Maryland's taxation department were accepted. One comment to clarify an individual "professional" under the Provider Qualification sections, and the difference in the standards for individual professionals vs. agency staff. The DDA responded a willing provider is an individual or entity that executes a Medicaid provider agreement and accepts Medicaid's payment for services rendered as payment in full. Individual professionals may choose to independently provide waiver services and must meet applicable qualification requirements. Agencies that either hire or sub-contract staff also have to meet the same specific qualification requirements. Participants' self-directing services can hire their own staff who must meet minimum qualifications or use a DDA-approved professional or agency, or a DDA licensed agency. The DDA did not accept a comment that only the participant and his/her team should determine employee qualifications. As per federal requirements, Medicaid must establish the essential minimum qualifications for providers and ensure those requirements are met when the service is provided.

Six comments were received regarding Appendix D. The DDA accepted a comment to require communication back to the participant and support broker related to Coordinators of Community Services (CCS) receipt, submission, and DDA approval of a budget modification. A comment to add "especially" to t: "In addition to objective assessments, the family is a key source of information on risk assessment and mitigation, especially when supporting participants under the age of 21." was accepted. A comment that "Provision of Information…" paragraph should address self-direction, available natural supports, free services and other services 'beyond' the DDA realm. The DDA responded all qualified providers must meet specific requirements prior to service delivery. A comment the current provider standard of completing all training within 90 days and First Aid/CPR certifications continue. The DDA clarified that a policy related to required basic core staff trainings required prior to service delivery and trainings will be issued. One comment to add "The CCS will

also inform the participant, his/her authorized representative, his/ her family members, and other identified planning team members about the option to select a Support Broker to help in the planning process and provides the team with a list of DDA certified supports brokers." The DDA explained this section of the waiver is specific to informing participants about informed providers. A comment that there be consideration for natural disaster and national emergency planning in the risk assessment section. The DDA responded that supporting families' tools will assess other areas of risk for the individual in addition to medical concerns such as natural disaster and national emergency planning. A comment to change the language to "Conduct required criminal background checks, Medicaid exclusion list…". under multiple services was not accepted. Criminal background checks must be conducted and submitted to DDA with the provider application. The DDA did not accept a comment that existing staff not be required to go through new training. To ensure direct care professional are appropriately trained on best practices and standards, all staff will need to complete the new DDA required training by July 1, 2019 or sooner. After July 1, 2019, all new hires must complete the DDA required training prior to service delivery.

32 comments regarding Appendix E were received. The DDA accepted comments related to defining family and family serving as staff, using a mix of traditional and self-direction service delivery models, increasing service management flexibility for self-directed services, Support broker choice, add language about PCP development and implementation, self-direction manual, and CCS training. Comments that an adult must have a legally responsible person to speak for them, to remove requirement for non-legal representative, guardian, or authorized representative to participate in self-direction, and remove any reference "that the participant… is capable of making informed decisions regarding how services are provided". The DDA explained adult participants can independently self-direct their services or choose a "designated representative." The participant, legal guardian, or his/her designated representative must be capable of making informed decisions to participate under this service delivery model. A comment to address how the Participant-Directed Budget is established. The DDA responded a participant's self-directed budget is determined through a person-centered planning process that offers budget flexibility while ensuring that the amount of the self-directed budget is not greater than the cost of traditional services for that individual. Comments the participant be able to manage adjustments in the plan and/or budgets without DDA approval. The DDA explained that a modification is needed in the PCP to support provider payment . For current services, a budget modification form will be used for plan changes. Not all changes need to be approved by the DDA; however they do need to be included in the PCP to authorize payment. A comment to add "less an appropriate, person-centered-determined administrative fee to cover the costs of the Fiscal Management Services (FMS) and Support Broker Services." to Appendix E-2 b.ii.3. The DDA explained that when the CCS and Team develop a PCP to meet assessed needs and service requests they are expressed in service units and cost reimbursement services. The self-directed budget dollar value will be assigned to the plan using payment rates from the traditional service delivery system. Comment to change language in Appendix E-1 j (e) to read: "The participant and his/her support team, which includes the CCS" for entities responsible for assessing performance. The DDA clarified the participant, legal guardian, designated representatives, and support team should continually assess performance, progress toward goals, and changing needs. This section is specific to the State's strategy and designation of an entity to assess performance of Support Broker Service. CCS are required to conduct quarterly monitoring of the provision of all waiver services. Comments to have a standard for "Initial Planning and Start up Activities" and Support Broker services. The DDA responded Support Broker services will be provided as an administrative service and no longer included as a stand alone waiver service. A comment that more than one FMS should be selected. The Department is in the process of issuing a Request for Proposal (RFP) for FMS services and will follow the procurement processes to identify the best qualified vendors. Comment related to Participant Exercise of Budget Flexibility, the waiver should make clear that modifications in the budget "amount" and not "shifting" of funds within the budget worksheet. The DDA responded the application template for this item provides two options to

check and does not support the entry of additional language or details. One comment that CCS provide proof of sharing information about SDS with participants. The DDA explained that CCS must document individuals choice related to SDS on the Freedom and Choice and Level of Care (LOC) forms required with the waiver application and on the annual LOC recertification. The DDA did not accept a comment to expand Employer Authority to all waiver services. Comment to eliminate the prohibition family members working as direct-care staff when another family member is the authorized representative and allow a direct-care staff member to also be an authorized representative with the restriction that someone else must sign the timesheet for participant employer. The DDA did not accept stating to prevent conflict of interest and ensure the participant's health and safety, relatives, legally responsible person and guardians will be able to provide specific services based on established criteria and safeguards. One comment to restore Support Broker role as a required member of the team with all the duties and responsibilities in the current waiver; to act as the agent for the participant and sign timesheets was not accepted. Support Broker services will be an option for participants using the self-directed service delivery model. Support Brokers can coach and mentor a participant, his/her legal guardian, or designated representative. A comment that (E1) language should be changed to "participant and authorized representative if applicable" not "or". The DDA did not accept, stating a participant or legal guardian may direct services or appoint a designated representative to direct on their behalf known. A comment to add URL or attach an official document to the waiver to represent the Life Course was not accepted, as the application does not support attaching documents and URL can change over time. The DDA did not accept a comment related to the make up of the participant's team. The participant or legal representative will determine the team member. A comment to add language about timelines of expenditure reports from the FMS to participant and Support Broker was not accepted. The DDA responded specific processes and timelines will be outlined in the FMS request for proposal and policies. A comment to add under Expenditure Safeguards, "There will also be a review to determine if Request for Budget Modification and Modified Service Funding Plan Request are being effectively and timely processed by the CCS to DDA for review and approval." The DDA did not accept, as the Request for Budget Modification and Modified Service Funding Plan Request will be phased out with the implementation of the Long Term Services and Supports IT system.

Four comments were received regarding Appendix F. The DDA accepted a comment that a grievance/complaint system should be established to provide participants a way to register and document grievances and complaints. Comment that SDS-specific forms and training need to be developed related to incident reporting for participants who reside in their own home or theirfamily's home was accepted. A comment that an additional dispute resolution process be established that is not conditional upon first requesting a Medicaid Fair Hearing. The DDA clarified that a dispute resolution process called a Case Resolution Conference (CRC) is offered, where the participant, his/her family, and the DDA engage in discussions surrounding the DDA decision or action in question. A CRC is not required, but provides an opportunity for a participant, his/her family, and representatives from the DDA to resolve a dispute before a participant's Medicaid Fair Hearing. A comment the Medicaid Fair Hearing letter should be mailed (or emailed) to any member of the planning team. The DDA explained the letter is mailed to the individuals, his/her family or his/her legal representative. The CCS and authorized representatives are also copied.

The DDA received two comments regarding Appendix I. The DDA accepted that comment that an adequate administrative rate be included for all services provided by or through a DDA licensed provider. The DDA did not accept the comment that under the traditional service model, there should be a process whereby participants, or their representatives, are provided a statement of services and payments. Current data systems do not support this type of report. The DDA will explore options under the Long Term Services and Supports information technology system.

Note: All rate study questions were referred to the Rate Study Consultant.

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 as 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 by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Hutchinson				
First Name:	Marlana R.				
Title:	Deputy Director, Nursing and Waiver Services				
Agency:	Maryland Department of Health – Office of Health Services				
Address :	201 West Preston Street, 1st Floor				
Address 2:					
City:	Baltimore				
State:	Maryland				
Zip:	21201				
Phone:	(410) 767-4003	**Ext:**		☐	**TTY**
Fax:	(410) 333-6547				
E-mail:	marlana.hutchinson@maryland.gov				

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Workman				
First Name:	Rhonda				
Title:	Director of Federal Programs				
Agency:	Maryland Department of Health – Developmental Disabilities Administration				
Address:	201 West Preston Street, 4th Floor				
Address 2:					
City:	Baltimore				
State:	Maryland				
Zip :	21201				
Phone:	(410) 767-8692	**Ext:**		☐	**TTY**

Fax:	(410) 333-5850
E-mail:	Rhonda.Workman@maryland.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Marlana Hutchinson

State Medicaid Director or Designee

Submission Date:	April 2, 2018

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Neall
First Name:	Robert R.
Title:	Secretary
Agency:	Maryland Department of Health
Address:	201 W. Preston Street
Address 2:	5th Floor
City:	Baltimore
State:	Maryland
Zip:	21201
Phone:	410-767-4639
Fax:	410-767-6489
E-mail:	Robert.neall@maryland.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Community Pathway renewal application enhances services and supports for individuals and families; updates provider and staff qualification standards with national standards; reflects new rates and payment methods; and provides new opportunities for participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans.

The Community Pathways Waiver renewal includes (1) the introduction of new services; (2) revisions to

service descriptions, requirements, limitations, and provider qualifications; (3) transition of some supports to another or new waiver services; (4) transition to new units, rates, and payment methodology (e.g. daily to hourly, monthly, and milestones); and (5) revisions to self-directed services covered under the employer and budget authorities as noted below. Some new services and changes to existing services will be available and in effect July 2018; some will transition during the first year; and others will be implemented July 2019.

The waiver includes the following new services: Employment Services ~~-~~; Career Exploration; Family and Peer Mentoring Services; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote ~~Monitoring~~Support Services; and three new Nursing Services.

Payment systems will transition to Maryland's Long Term Services and Supports (LTSS) system on July 1, 2019. New service units and rates will be implemented July 1, 2018 unless otherwise noted below.

SERVICE ENHANCEMENTS AND TRANSITIONS - MEANINGFUL DAY SERVICES

Meaningful Day services include: Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation. A participant's Person-Centered Plan may include a mix of Meaningful Day services as provided on different days for the first waiver year. Beginning July 2019, these services will be provided on an hourly basis providing new opportunities and flexibility for participants to receive various Meaningful Day services to meet their individualized goals on the same day. Participants will continue to have access to current professional services (e.g. nursing and behavioral supports) being provided until they transition during the first year to the specific stand alone services. Meaningful Day services with the exception of Supported Employment and Employment Services are limited to 40 hours per week. Participants also have access to various support services including Personal Supports, Assistive Technology and others to meet additional service needs as further noted in Appendix C.

Supported Employment

1. Supported Employment services will end on June 30, 2019 and transition to the new Employment Services or Career Exploration Services.
2. Employment Services include discovery, job development, on-going job supports, follow along supports, self-employment development supports, and co-worker employment supports. Employment Services are based on Communities of Practice including new employment certifications requirements for staff qualification and new rates and payment reimbursement methodology based on the service scope and rate study including hourly, monthly, and milestone payments. This service will begin July 1, 2019. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.
3. Supported Employment facility based, small group, and large group supports will now be supported under Career Exploration. Career Exploration are time-limited services to help participants learn skills to work toward competitive integrated employment. Participants must have an employment goal within their Person-Centered Plan that outlines how they will transition to community integrated employment (such as participating in discovery and job development). Career Exploration will transition from a daily rate to an hourly rate on July 1, 2019. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

Employment Discovery and Customization will end on June 30, 2019 and transition to the new Employment Services that includes discovery, job development, on-going job supports, follow along

supports, self-employment development supports, and co-worker employment supports.

Community Learning Services changes include:
1. The name will change to Community Development Services.
2. The scope includes supporting the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities.
3. An individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. The individualized schedule will be based on a Person-Centered Plan.
4. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

Day Habilitation changes include:

1. An individualized schedule to provide an estimate of what the participant will do and where the participant will spend their time when in this service. The individualized schedule will be based on a Person-Centered Plan.
2. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

SERVICE ENHANCEMENTS AND TRANSITIONS - RESIDENTIAL SERVICES

Residential Services include: Community Living-Group Home, Community Living – Enhanced Supports, Shared Living, and Supported Living.

Residential Habilitation changes include:
1. The name will change to called Community Living- Group Home services.
2. Services are to be provided to no more than four (4) individuals (including the participant) in one home unless approved by the DDA.
3. Participants will have access to current professional services being provided (e.g. nursing and behavioral supports) until they transition during the first year to the specific stand-alone services. New service rates will be implemented July 1, 2019.

Community Living-Enhanced Supports
1. Community Living—Enhanced Supports is a new service that supports participants, who exhibit challenging behaviors or have court ordered restrictions, with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, by providing additional observation and direction in a community residential setting.
2. Providers must have Licensed Behavioral Analysis (LBA), Board Certified Behavioral Analysis (BCBA), and Psychologist on staff that have experience in the following areas: working with deinstitutionalized individuals; working with the court and legal system; trauma informed care; behavior management; crisis management models; and counseling. Direct service staff must have training in trauma informed care; de-escalation; and physical management. Based on the needs of the participants, the following additional training will be required for staff including: working with sex offenders; working with people in the criminal justice system; and/or working with the Community Forensics Aftercare program.

Shared Living changes include:
1. The scope of services includes recruiting for ~~Host~~ host ~~H~~homes ~~providers~~; facilitating recruitment and matching services of participants and ~~Host~~ host ~~Homes~~ homes based on the participant's preferences

and choice; overseeing quality management and monitoring compliance with program requirements once the arrangement is established; and compensation to ~~Host~~ host ~~Home~~ homes for additional household cost.
2. During the first waiver year, Shared Living services will transition to the new scope, units and rates.
3. Current services provided such as Nursing, Behavioral Supports, and Personal Support services will transition during the first year to the specific stand-alone service.

Supported Living
1. Supported Living is a new service that provides participants with a variety of individualized services that support living independently in the community beginning July 2019.
2. Supported Living services include assistance and facilitation with finding an apartment or home, roommates, and shared supports based on the participant's preferences and choice; overseeing quality management; and monitoring compliance with program requirements once the arrangement is established.
3. If participants choose to live with housemates, no more than four (4) individuals (including other participants receiving services) may share a residence. All residents must have a legally enforceable lease that offers them the same tenancy rights that they would have in any public housing option.

SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES

Assistive Technology and Adaptive Equipment changes include:
1. The name will change to Assistive Technology and Services.
2. Provider qualifications are based on the type of assistive technology sought.
3. Service scope was expanded to demonstrate the various supports available and includes a needs assessment, training and technical assistance, repairs and maintenance.
4. Assistive Technology, recommended by the team, that costs up to $1000 per item does not require a formal assessment

Behavioral Support Services changes include:
1. The scope of services includes behavioral assessment, development of a behavioral plan, behavioral consultation, and brief implementation supports.
2. The behavioral assessment and behavioral plan will be reimbursed based on a milestone.
3. Behavioral Assessment services are limited to one per year unless otherwise approved by the DDA.
4. Behavioral Consultation services and Brief Support Implementation Services are based on assessed needs, supporting data, plan implementation, and authorization from the DDA.
5. Provider qualifications and staff requirements were enhanced to include staff training in Applied Behavioral Analysis and tiered behavioral supports.

Environmental Assessment changes include:
1. Addition of new Environmental Assessment Service Report to document findings and recommendations based on an onsite environmental assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g. family, direct support staff, delegating nurse/nurse monitor, etc.).

Environmental Accessibility Adaptations changes include:
1. Service name changed to Environmental Modifications.

2. An environmental assessment must be completed as per the environmental assessment waiver services requirements.
3. Environmental Modifications recommended by the team that cost up to $2,000 does not require a formal assessment.
4. Limitation changed from not to exceed $17,500 (combined total with Vehicle Modifications) over an individual's lifespan unless authorized by DDA to not to exceed a total of $15,000 every three years independent of Vehicle Modifications.

Family and Individual Support Services changes include:
1. Current services to (a) link participant with the community, (b) provide training, facilitating opportunities, or accompanying the participant, and (c) provide family support groups and training will now be provided under new services, revised services, or current services such as Participant Education, Training, and Advocacy Supports; Family Caregiver Training and Empowerment Services; Housing Support Services; Community Development Services; and Coordination of Community Services.
2. Individual Directed Goods and Services will continue to be provided for participants choosing the self-directed service delivery model and will now be called Individual and Family Directed Goods and Services. The service limit was increased from $2,000 to $5,500 per year from the total self-directed budget of which $500 is dedicated to staff recruitment and advertisement.

Family and Peer Mentoring Supports is a new service that provides mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and his or her family members. Family and Peer mentors share life experiences and explain community services, programs, and strategies they have used to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and his or her family.

Family Caregiver Training and Empowerment is a new service that provides education and support to the unpaid family caregiver of a participant that preserves the family unit and increases confidence, stamina and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the Person-Centered Plan.

Housing Support Services
1. Housing Support Services is a new service that provides time-limited tenancy supports to help participants navigate housing opportunities; address or overcome barriers to housing; and secure and retain their own home.
2. Housing assistance staff training requirements include: conducting a housing assessment; affordable housing resources; leasing processes; and tenant and landlord rights and responsibilities.

Live-in Caregiver Rent changes include:
1. Service name changed to Live-In Caregiver Supports.
2. Scope of services now includes additional cost of rent and food that can be reasonably attributed to an unrelated live in personal caregiver who is residing in the same household with an individual.

Nursing Services
1. Three new nursing services will be offered as standalone waiver services including Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services.
2. Nursing services are available under both the self-directed and traditional service delivery models.

Participant Education, Training, and Advocacy Supports is a new service that provides training programs,

workshops and conferences that help the participant develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.

Personal Supports changes include:

1. Personal Supports service scope was updated to reflect individualized habilitative supports, delivered in a personalized manner, to support independence in a participant's own home and community in which the participant wishes to be involved based on their personal resources.
2. Personal Support services assist participants who live in their own or family homes in acquiring the skills necessary to maximize their personal independence. These services include: in home skills development, community integration and engagement skills development, and incidental personal care services during in home skills development and community activities.
3. Transportation cost associated with the provision of services will be covered within the new rate effective July 2019.
4. Provider and staff qualifications enhanced including two years experience for staff providing training on money management, time management and community resources.
5. New rates will be implemented on July 1, 2019.

Remote ~~Monitoring~~ Support Services is a new service that provides oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs.

Respite Care Services changes include:

1. Services can be provided at an hourly rate for 8 hours or less; or at a day rate for over 8 hours daily.
2. Respite services may not exceed 45 days or 360 hours within a twelve month period. The total cost for daily, hourly, and camp cannot exceed $7,248 within a twelve month period.

Transportation changes include:

1. Scope of services expanded to include prepaid transportation cards.
2. Limitation increased for traditional service delivery model from $1,400 to $7,500 per year to support community integration and engagement.

Vehicle Modifications limitation changed from not to exceed $17,500 (combined total with Environmental Accessibility Adaptations) over an individual's lifespan unless authorized by DDA to not to exceed a total of $15,000 every ten years independent of Environmental Modifications.

SELF DIRECTION

Participants or their legal guardian have the option to choose the self-directed service delivery model. Adult participants can independently self-direct their services or choose a "designated representative." A designated representative is a person authorized by the participant, on the form provided by the Department, to serve as a representative in connection with the provision of services or supports under the self-directed services delivery model. The participant, legal guardian, or his/her designated representative must be capable of making informed decisions in order to participate under this service delivery model. ~~Participants may direct his or her own services or appoint an authorized representative to direct on their behalf which is known as the Self-Directed Service Model.~~ Participants choosing to use the self-directed service delivery model will continue to have access and support from Advocacy Specialist, Coordinators of Community Services, Support Brokers, and Fiscal Management Services. Support Broker services will be an optional administrative service and no longer included in the participant's self-directed budget. Transition of provider owned and operated Day Habilitation services for participants self-directing will

occur during the first year during annual Person-Centered Plan meetings or sooner.

Participants can exercise employer or budget authorities on various services. Employer authority means the participant has decision making authority over staff that provide specific services. The participant is the common law employer. Employer authority services opportunities are available for the following services: (1) Community Development Services; (2) Personal Supports; (3) Respite Care; (4) Transportation; and (5) Supported Employment.

Budget authorities means the participant has decision making authority over their self-directed service budget. Budget authority opportunities are available for the following services: (1) Assistive Technology and Services; (2) Behavioral Support Services; (3) Community Development Services; (4) Day Habilitation; (5) Employment Discovery and Customization; (~~5~~6) Employment Services; (~~6~~7) Environmental Assessment; (~~7~~8) Environmental Modifications; (~~8~~9) Family and Peer Mentoring Supports; (~~9~~10) Family Caregiver Training and Empowerment Services; (~~10~~11) Housing Support Services; (~~11~~12) Individual and Family Directed Goods and Services; (~~12~~13) Live-In Caregiver Supports; (~~13~~14) Nurse Consultation; (~~14~~15) Nurse Health Case Management; (~~15~~16) Nursing Case Management and Delegation Services; (~~16~~17) Participant Education, Training, and Advocacy Supports; (~~17~~18) Personal Supports; (~~18~~19) Remote ~~Monitoring~~Support Services; (~~19~~20) Respite Care Services; (~~20~~21) Supported Employment; (~~21~~22) Supported Living; (~~22~~23) Transition Services; (~~23~~24) Transportation; and (~~24~~25) Vehicle Modifications.

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 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 of Maryland submitted the Statewide Transition Plan (STP) for Compliance with Home and Community-Based Setting Rule on March 12, 2015. The State received initial approval from CMS on August 2, 2017, which is reflected below. The plan is posted to the Department website at:

https://mmcp.health.maryland.gov/waiverprograms/Pages/Community-Settings-Final-Rule.aspx
The State assures that the information regarding the settings transition plan included with this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan (STP). The State will implement any required changes upon final approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

The STP covers three major areas: Assessment, Proposed Remediation Strategies, and Public Input. It identifies the framework and strategy for achieving and maintaining compliance with the federal requirements for HCB settings in Maryland.

The Maryland Department of Health (DMH), as the single state Medicaid agency, is responsible for all 1915 (c) and 1915 (i) programs. DMH's Office of Health Services (OHS) and the Developmental Disabilities Administration (DDA) are responsible for the administration of the Community Pathways Waiver. Below is information copied from the STP specific to the Community Pathways Waiver.

Initial compliance findings for the Community Pathways program was based on: an assessment of provider and site data; and waiver application and regulations service definitions, rules, and policies currently governing all setting, both residential and non-residential. The program summary and initial findings were used to identify areas of concern which are reflected in Maryland's proposed remediation strategies section including quality assurance processes to ensure ongoing compliance. Maryland is committed to engaging with stakeholders and has sought public input from various stakeholders including participants, family members, self-advocates, associations, advocacy groups, and others throughout the process of the transition plan development.

Preliminary assessment of the Community Pathways Waiver application, State Plan Amendment, and programs regulations are summarized below:

COMAR Regulations 10.22.01 – 10.22.12 and 10.22.14 – 10.22.20
Title - Developmental Disabilities Administration – Various Titles
Preliminary Findings - Missing criteria dictated by the Community Settings Final Rule and noncompliant findings related to freedom from restraint; legally enforceable agreement by the individual receiving services; conflict of interest related to development of person centered service plans; and setting options. Reference – Appendix K

ASSESSMENT OF MEDICAID WAIVER APPLICATION AND STATE PLAN:
COMAR Regulation 10.09.26
Title - Community Pathways Waiver
Preliminary Findings - Missing criteria dictated by the Community Settings Final Rule and non-compliance findings related to integration to the community, individual selections, and independence. Reference – Appendix D

There is a comprehensive quality plan in place to monitor service delivery and ensure continuous compliance with HCB setting criteria. The program's specific quality plans is detailed in Appendix H of the waiver application. This plan includes the details of the quality assurances developed and implemented by the State, including policies and processes in place to ensure quality of Person-Centered Plans of service and participant's health and welfare.
Individuals who are enrolled in and receiving services from one of the HCBS programs may also be referred to, in this Statewide Transition Plan, as participants, children, consumers, individuals, or clients.

For the Community Pathways waiver, the service plan is referred to as the Person-Centered Plan (PCP) and case managers are referred to as Coordinators of Community Services.

SECTION 1: ASSESSMENT OF MARYLANDS HCBS PROGRAMS

COMMUNITY PATHWAYS WAIVER BACKGROUND

This 1915(c) waiver is administered by the Developmental Disabilities Administration (DDA) and provides services and supports to individuals with developmental disabilities of any age, living in the community through licensed provider agencies or self-directed services. The Community Pathways Wavier covers 19 different types of services delivered by licensed service providers and independent providers throughout the state. This waiver also gives the option of self-direction. Under self-direction, individuals are required to obtain the services of a Support Broker and Fiscal Management Service provider, who will assist in the planning, budgeting, management and payment of the person's services and supports. Individuals must need the level of care required to qualify for services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The Community Pathways Waiver offers the following services:

1. Assistive Technology and Adaptive Equipment
2. Behavioral Supports
3. Community Learning Services
4. Community Residential Habilitation Services
5. Day Habilitation – Traditional
6. Employment Discovery and Customization
7. Environmental Accessibility Adaptations
8. Environmental Assessment
9. Family and Individual Support Services
10. Fiscal Management Services
11. Live-In Caregiver Rent
12. Medical Day Care
13. Personal Supports
14. Respite
15. Shared Living
16. Support Brokerage
17. Supported Employment
18. Transition Services
19. Transportation
20. Vehicle Modifications

ASSESSMENT OF THE DDA'S SERVICE DELIVERY SYSTEM SETTINGS

From July through October 2014, the OHS and DDA completed reviews and analysis of: Maryland's National Core Indicator survey results; licensed providers data; self-assessment surveys; and the DDA Statute, Community Pathways application, and State regulations which are further described below.

Through routine monitoring efforts, including quality reviews, site visits, data analysis, and communication with participants and providers, Maryland is aware of many strengths and weaknesses for the DDA service delivery system as they relate to the HCB setting rule.

The OHS and DDA, or their designated agents, currently monitor providers and service delivery through a variety of activities, including licensure surveys, site visits, Individual Plan reviews, complaints and incidents reviews, and National Core Indicator (NCI) surveys. These efforts will continue throughout the transition process and will be updated to include the new federal standards and other strategies recommended by stakeholders.

The Office of Health Care Quality (OHCQ) is a designated state licensing agent of the DDA. OHCQ is authorized to issue new licenses and renew licenses for existing licensed providers. It may conduct inspections as part of investigations or regular surveys and cite providers for noncompliance with the regulatory standards from the Code of Maryland Regulations (COMAR) Title 10 Subtitle 22 related to licensure and quality of care. Based on the severity of the finding, the OHCQ may require a plan of

corrections from the provider or issue sanctions and pursue disciplinary action of license suspension or revocation for deficiencies cited from this subtitle.
Participant's PCPs are reviewed by several entities to ensure they comply with programmatic regulations, including CCS and their supervisors, DDA regional office staff during site visits and quality audits, and the OHCQ during surveys and investigations.

CCS conduct quarterly face-to face visits to monitor service delivery including progress on goals, assessment of services as per the plan, status and confirmation of health services, eligibility, and incidents.

In accordance with the Department's Policy on Reportable Incidents and Investigations (PORII), all entities associated with the Community Pathways Waiver are required to report alleged or actual significant incidents in the DDA incident module including unauthorized restraints. Follow-up and investigative actions are taken as per policy and data are analyzed for trends and to identify areas in need of improvement.

Any person who believes that an individual has been subjected to abuse, neglect, or exploitation is required to report the alleged abuse, neglect, or exploitation immediately to the police, Adult Protective Services (APS) or Child Protective Services (CPS) office, and the DDA Regional Office. The complete incident report must be submitted within one working day of discovery.
The DDA also utilizes the National Core Indicators surveys to measure and track performance related to core indicators. Core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

The DDA also receives guidance from CMS, The Hilltop Institute, and stakeholders when establishing criteria for engaging in site-specific assessments.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS
Below are brief summaries of each activity OHS and DDA undertook to complete an initial analysis of the DDA service delivery system for compliance with the new HCB setting rule. This initial analysis is general in nature and does not imply that any specific provider or location is non-compliant solely by classification or service type.

National Core Indicators (NCI)
The DDA became a member of the NCI in 2011. Surveys include an adult consumer survey, family survey, and guardian survey which have been conducted for the past three years. The NCI Adult Consumer Survey is an interview conducted with a sample of individuals who are receiving DDA funding for services. This survey is used to gather data on approximately 60 consumer outcomes. Interviewers meet with individuals to ask questions about where they live and work, the kinds of choices they make, the activities they participate in within their communities, their relationships with friends and family, and their health and well-being. NCI indicators linked to the Final Rule are reflected in Appendix 14.
For some areas Maryland scored above the national average and in other areas below. Examples, based on results from the 2013- 2014 surveys, include the following:

- 74% of respondents from Maryland and 82% across NCI states reported that they decide or have input in choosing their daily schedule
- 85% of respondents from Maryland and 87% across NCI states reported that they choose or have input in choosing how to spend their money
- 82% of respondents from Maryland and 91% across NCI states reported that they decide or have input in choosing how to spend free time
- 75% of respondents from Maryland and 71% across NCI states reported that they went out for entertainment in the past month
- 49% of respondents from Maryland and 48% across NCI states reported that they went out to a

religious service or spiritual practice in the past month
- 64% of respondents from Maryland and 45% across NCI states reported that they went out on vacation in the past year
- 72% of respondents from Maryland and 76% across NCI states reported that they have friends other than family or paid staff
- 26% of respondents from Maryland and 26% across NCI states reported that they want to live somewhere else
- 43% from Maryland and 34% across NCI states reported that they want to go somewhere else or do something else during the day among respondents with a day program or regular activity

If applying a standard of 100%, as required in CMS for reporting of quality measures in 1915(c) Home and Community-Based waivers, Maryland did not meet this standard in any of the HCB setting requirements noted above.

Licensed Provider Data
Community Pathways' waiver provider may specialize in providing services to a particular group, such as individuals with medical complexities, behavioral challenges, or those who are court/forensically involved. Providers may also be licensed to provide more than one waiver service.

The DDA reviewed data on licensed providers including the number of people supported, number of sites, and number of people per site. These data will be used to target providers and sites for further reviews. Highlights are indicated below:
Personal Supports
- DDA funds 112 licensed providers to provide services
- 2,681 individuals receive these services in 2,502 sites.
    - 2,358 sites have one individual
    - 117 sites include two individuals
    - 24 sites include three individuals
    - 3 sites include four individuals

Reference: Appendix 8
Residential Habilitation – Alternative Living Unit (ALU)
- DDA funds 118 licensed providers to provide ALU services
- 3,100 individuals receive these services in 1,320 sites.
    - 270 sites have one individual
    - 382 sites include two individuals
    - 648 sites include three individuals
    - 20 sites include four individuals

Reference: Appendix 8
Residential Habilitation – Group Home (GH)
- DDA funds 87 licensed provider to provide GH services
- 2,945 individuals receive these services in 779 sites.
    - 34 sites have one individual
    - 40 sites include two individuals
    - 203 sites include three individuals
    - 369 sites include four individuals
    - 81 sites include five individuals
    - 23 sites include six individuals
    - 13 sites include seven individuals
    - 16 sites include eight individuals

Reference: Appendix 8
Shared Living
- DDA funds 14 licensed providers to provide Shared Living services

- 212 individuals receives these services in 179 homes
  - 149 homes have one waiver individual
  - 27 homes include two waiver individuals
  - 3 homes include three waiver individuals

Reference: Appendix 8

Medical Day Care Services

- As of August 8, 2016 there were 645 individuals receiving services from 55 providers of Medical Day Care

Day Habilitation

- DDA funds 106 licensed providers to provide day services
- 8,838 individuals receive these services in 209 sites.
- Day provider site consumer count range is 1 – 372

Reference: Appendix 9

Supported Employment (SE)

- DDA funds 97 licensed provider to provide SE services
- 3,941 individuals receive these services.
- SE providers support from 1 – 527 individuals.

Reference: Appendix 9

Based on this information, further review and heightened scrutiny is needed to assess whether services or settings receiving Medicaid-funded HCBS may have institutional qualities or may be isolating individuals from the broader community due to structure of the setting, multiple provider settings being close to each other or on the same grounds, and settings that serve only those with disabilities with no or limited community interactions.

In addition, service providers shared concerns related to limited community options in rural areas of the State due to inadequate community transportation options and limited community business and resources such as libraries, malls, and restaurants, which have hindered opportunities to seek employment and work in competitive and integrated settings, engage in community life, and receive services in the community to the same degree as individuals who do not receive HCBS.

Initial Self-Assessment Surveys for Residential Services

During July through October of 2014, the MDH worked with the Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys that were specific to participants receiving residential habilitation services and their representatives, providers, and case managers. This process was an initial setting analysis and general in nature across three program populations including the Autism, Community Pathways, and the Home and Community-Based Options Waivers. To support participation in the survey, participant specific information such as name and program was not collected. This assessment process does not suggest that any specific program, provider or location is non-compliant solely by classification. Compliance will be determined through further analysis that might include: additional self-assessments for providers and participants, on-site reviews, stakeholder input, and further analysis of programmatic data. Below is a brief summary of the methodology and analysis of the three self-assessments. A full analysis and recommendations were made by the Hilltop Institute that can be found in Appendix 10.

Based on the information gathered from the preliminary survey, areas that have been identified for further review include those settings that may be in institutions, settings that may be isolating to participants (multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates (such as access to food, locking the front door, and lease issues).

Further review should include assessment of criteria for settings presumed not to be home and community-based: settings near other settings run by the provider for people with disabilities, an individual's control

over their personal resources, community access and involvement, and the ability to file complaints. Additional areas of concern in residential settings are whether individuals may execute a lease, may choose a private room or a roommate, are guaranteed privacy and flexible access to food, and experience significant barriers related to provisions of the Community Settings Final Rule.

Assessments of DDA Statute, Waiver Application, and Regulations

Between September and November of 2014, the DDA completed a review of the State regulations including the Code of Maryland Regulations (COMAR) 10.09.26, 10.09.48, and 10.22 to determine the current level of compliance with the new federal requirements. COMAR 10.09 are specific to the Community Pathways Wavier and DDA's targeted case management services under the Medical Care Programs. COMAR 10.22 are specific to Developmental Disabilities and include 20 individual chapters on specific topics or services such as definitions; values, outcomes, and fundamental rights; individual plan; vocational programs; and community residential services. Regulations and statutes specific to institutional settings only were not included as they are not considered community or comply with the rule. In order to crosswalk regulation and waiver applications, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings", developed by the Association of University Centers on Disabilities (AUCD), National Association of Councils on Developmental Disabilities (NACDD), and the National Disability Rights Network. This has allowed for consistency across programs and documents.

The preliminary review resulted in identification of missing criteria dictated by the Community Settings Final Rule and language that conflicts or is out of compliance with the rule that will require remediation. At times, language is noted that is similar to the federal requirements but may not apply to all services or elements of the requirement. See Appendix K for specific details.

PRELIMINARY FINDINGS RELATED TO THE DDA SERVICE DELIVERY SYSTEM
Through the process described above, the State has determined that the following waiver services comply with the regulatory requirements because they are individualized services provided in the participant's private home or community:

1. Assistive Technology and Adaptive Equipment – technology and equipment to help participants live more independently
2. Behavioral Support Services – assist individuals who exhibit challenging behaviors in acquiring skills, gaining social acceptance, and becoming full participants in the community. Services are provided in residential habilitation sites, participant's homes, and other non-institutional settings to help increase independence including: behavior consultation; behavior plan development and monitoring; behavioral support; training for families and other service providers; behavioral respite; and intensive behavioral management services. Current regulations, COMAR 10.22.10.08 and 10.22.10.09, permit physical restraint and use of mechanical restraints and supports when the individual's behavior presents a danger to self or serious bodily harm to others or medical reasons. Regulations require a formal behavioral plan that includes historical information, analysis, strategies, and informed consent from the individual or guardian, as applicable.
3. Employment Discovery and Customization – time-limited, community-based services for up to six months, designed to provide discovery, customization, and training activities to assist a person in gaining competitive employment at an integrated job site where the individual is receiving comparable wages. Regulations are being drafted by a stakeholder group which will be reviewed for compliance with the Community Settings Final Rule.
4. Environmental Accessibility Adaptations – adaptations to make the environment more accessible
5. Environmental Assessment – assessment for adaptations and modification to help participants live more independently
6. Family and Individual Support Services – assistance in making use resources available in the community while, at the same time, building on existing support network to enable participation in the community

7. Fiscal Management Services – assistance with the financial tasks of managing employees for participants who self-direct their services
8. Live-In Caregiver Rent – funding for caregiver rent
9. Personal Supports – hands-on assistance or reminders to perform a task in own home, family home, in the community, and/or at a work site
10. Respite – short-term relief service provided when regular caregiver is absent or needs a break. The service is provided in the home and/or community settings to meet planned or emergency situations, giving caregivers a time free from their role as care provider.
11. Support Brokerage – assistance with the self-directed services
12. Transition Services – one-time set-up expenses when moving from an institution or a provider setting to a living arrangement in a private residence
13. Transportation – services include mobility and travel training including learning how to access and utilize informal, generic, and public transportation for independence and community integration.
14. Vehicle Modifications – modifications to vehicles to meet participant's disability-related needs.
15. Community Learning Services - Community-based services, activities, support, and education to help individuals whose age, disability, or circumstances currently limits their ability to be employed, and/or participate in activities in their communities. They assist in developing the skills and social supports necessary to gain, retain, or advance in employment. Service can be provided in groups of no more than four (4) individuals with developmental disabilities, all of whom have similar interests and goals as outlined in their person-centered plan except in the case of self-advocacy groups. They can also provide assistance for volunteering and retirement planning/activities. Community Learning Services must be provided in the community and are not allowed to be provided in residential or day facilities owned or controlled by Medicaid providers.

MDH also recognizes that respite care has been an approved service on many waiver applications in a variety of community and institutional locations. Respite care is defined as short-term relief service provided when regular caregiver is absent or needs a break. The service will remain in the Community Pathways waiver and will be provided in the home and/or community settings to meet planned or emergency situations, giving caregivers a time free from their role as care provider. Based on guidance received from CMS, the MDH believes that because Respite Services are allowable in facilities that do not meet the HCB setting criteria that these settings will not need further review.

The State has determined that the following waiver services, associated regulations, and processes need further review and remediation to fully comply with the regulatory requirements. MDH will work with stakeholders and providers of these services to implement the changes needed to achieve full compliance.

1. Community Residential Habilitation - Services are provided in either group homes (GHs) or alternative living units (ALUs) and help individuals learn the skills necessary to be as independent as possible in their own care and in community life.

   ALUs can be licensed to support one to three individuals and GHs can be licensed for up to eight individuals. Special permission is required for any individual living in a home of greater than three individuals. In reviewing these exceptions, the following are considered: 1) the wishes of the individuals living in or proposing to live in the home, 2) the interests of the individuals living in or proposing to live in the home, 3) health and safety, and 4) other exceptional circumstances. Provider data noted above indicated there are several residential provider sites with more than three individuals. These sites will need further review to ensure compliance with the rule.

   In addition, some sites have farmstead or disability-specific farm community characteristics or have multiple service settings co-located which will require further review.
   Residential providers have various sites that are established to meet the individual needs of the resident. Providers shared concerns with the self-assessment survey as it was based on a single site or facility and answers to questions would vary depending if based on specific sites. Further review of each site

is needed to identify areas of concerns per site.
Residential service providers also use various leases or residency agreement which need further review to determine if these are legally enforceable. Stakeholder input included the suggestion for a standardize lease or agreement.

2. Day habilitation – Facility-based services designed to provide vocational assessment, training in work, social, behavioral, and basic safety skills. They are intended to increase independence and develop and maintain motor skills, communication skills, and personal care skills related to specific habilitation goals that lead to opportunities for integrated employment.

   Data demonstrate that the current service delivery system supports close to 9,000 individuals in these service with one provider supporting 372 individuals. A few providers have transitioned their historic programs to focus on community-based activities and individualized integrated employment for people they serve. The DDA is working with these agencies to obtain transitioning strategies, challenges, and opportunities that can be shared with other providers to assist with transitioning and compliance with the Community Settings Final Rule.

3. Medical Day Care Services – Services provided in medically supervised, health-related services program provided in an ambulatory setting to support health maintenance and restorative services for continued living in the community.

   Current regulations COMAR 10.09.07 and 10.09.54 do not address many of the criteria from the HCB setting rule. Further review is needed to ensure that individuals who receive this Medicaid service are truly integrated and have full access to the greater community. Medical Day Care providers are approved and monitored by the Office of Health Services as part of the Medical Day Care Waiver. Therefore, these services are being reviewed for compliance with the Community Settings Final Rule under the Medicaid Day Care Waiver.

4. Personal Supports – Services include hands-on assistance, prompting to perform a task, or supports for independent living. These supports are provided in participant's own home, family home, or in the community. Currently there are three homes supporting four individuals receiving services. One of the homes is a family where all members are receiving supports. The individuals at the other two homes are exploring other independent living arrangements.

5. Shared Living – An arrangement in which an individual, couple or a family in the community share life's experiences and their home with a participant. The structure and expectations of this service are such that it is similar to a family home, with expectations that the individual, couple, or family supports the waiver participant in the same manner as family members including engaging in all aspects of community life. Maryland's requirements for shared living settings are small with no more than three individuals requiring support living in the home. The experience of the individuals being supported through shared living will be similar to individuals living in their own or family home.

6. Supported employment - Services are community-based services that assist an individual with finding and maintaining employment or establishing their own business. Supports may include job skills training, job development, and ongoing job coaching support. They are designed to assist with accessing and maintaining paid employment in the community.

Maryland is a member of the State Employment Leadership Network (SELN), which includes state development disability agencies that share, educate, and provide guidance on communities of practice and policies around employment. Part of this effort includes the use of data to guide daily systems management. Maryland is currently assessing employment outcomes data for 2014, which includes various setting types, such as integrated jobs (i.e. individual competitive job, individual contracted job, group

integrated job, and self-employment), facility-based employment, and community-based non-work.

The data system is administered by the Institute of Community Inclusion (ICI) at the University of Massachusetts. This data is collected twice a year and covers a two-week period. The data is captured in the month of May and October. Each provider is required to report on each person being supported in Day Habilitation, Employment Discovery and Customization, Supported Employment and Community Learning Services. Providers choose whichever two-week period in that month they want. Providers report on all activities for each person during that specific two-week period. This data has been collected since 2013 twice a year. This data has been used to shape future policies, build provider capacity and create an infrastructure for training and provider support.

The most recent data below reflects the outcomes from data collected in October 2016:

Employment Related

	Individual Competitive Employment	Individual Contracted Work	Self-Employment	Group Integrated Job	Facility-Based Job
Number of Individuals	2361	431	54	1116	2448
Percentage	20.1%	3.7%	.5%	9.5%	20.8%

Non Work Related Day Activities

	Community- Based Non Work	Facility- Based Non Work
Number of Individuals	4995	6406
Percentage	42.5%	54.5%

Facility-based jobs and facility-based non-work activities will need further review.

VALIDATION OF FINDINGS AND SETTINGS INVENTORY –ON SITE ASSESSMENTS

Provider Self-Assessments Validation

The DDA requested that The Hilltop Institute explore multiple strategies to for validation of the provider self- assessments including:

- Geomapping
- CSQs
- OHCQ citation tags
- Employment data

Relevant data/indicators were linked to specific regulations within the HCBS community settings final rule criteria. When multiple validation strategies exist for a single question, the most appropriate one will be chosen based on the data. Information was shared with the DDA Transition Advisory Team for input and recommendations.

Medicaid Re-Validation

As part of the MDH's re-validation process, site visits are made to all Medicaid providers to meet the Affordable Care Act (ACA) standards. During the site visit, the surveyor report any observed unsafe conditions and/or inappropriately locked (or unlocked) spaces. They will take photos of the facility to document whether it is open and operational. They will scan for accessibility and settings structure such as multiple sites in one location, farmsteads, and other potential isolating characteristics. Pictures and narrative information is then shared with MDH and administrating agencies such as the DDA for further

assessment.

Community Pathways Waiver Independent Reviews
To further assess and enhance the services delivery system and support quality of life for people utilizing communities of practice, the DDA procured consultants to review the Community Pathways Waiver including services definitions, quality enhancement, and performance measures; self-direction processes and policies; and targeted case management including person-centered planning. These reviews include various stakeholder input opportunities, such as public listening sessions facilitated by the consultants, and focused reviews for compliance with the Community Settings Final Rule. Information related to the review can be viewed at: https://dda.health.maryland.gov/Pages/waiver%20feedback.aspx

DDA Provider Specific Surveys
In partnership with the DDA Transition Advisory Team and the assistance of The Hilltop Institute, the MDH developed new provider specific (i.e. Residential and Non-Residential) comprehensive self-assessment surveys specific to the DDA service delivery system and HCB setting requirements to provide additional data to determine compliance. As noted in The Hilltop Institute's initial survey report there were several limitations to the initial surveys as they did not account for different waiver populations and provider systems. Prior to the implementation of a provider self-assessments survey, the MDH piloted test surveys with a volunteer group or providers for both the Residential and Non-Residential Surveys to test the survey questions and results. Surveys were revised based on recommendations from the DDA Transition Team and dissemination to related provider groups.

Non-Residential Provider Self-Assessment
MDH, with information supplied by DDA, sent waiver providers an email on April 22, 2016 announcing the necessity of completing the upcoming provider self-assessment. The email also contained a PDF version of the assessment instrument for providers to preview and information regarding webinars to assist providers in completing the self-assessments. MDH also sent providers a personalized email on April 27 announcing the opening of the self-assessment after the webinar on April 28. Webinars held on April 28 and April 29 walked providers through the assessment and helped answer questions. Providers were further instructed to complete self-assessments for each service at each site a provider operated.

Providers were instructed to complete the self-assessments by May 16, 2016; however, the online assessment remained open until July 25, 2016.

In order to determine provider compliance, relevant questions/indicators were linked to specific regulations within the HCBS community settings final rule criteria. MDH had developed a compliant/non-compliant analysis scheme in which providers who were non-compliant on any one indicator for a specific regulation were deemed non-compliant for that entire regulation. DDA agreed to use this same analysis scheme. Additional key questions were denoted as "red flag questions." Providers who were deemed non-compliant on these questions may require more immediate attention from DDA.

One hundred seventeen (117) providers completed assessments, totaling 377 completed assessments. The plurality of the service settings are day habilitation settings, which account for 48 percent of the completed assessments. The Hilltop Institute "HCBS Final Rule: DDA Non-Residential Provider Self-Assessment Summary" September 22, 2016 full report can be viewed on the MDH website.

Residential Provider Self-Assessment
DDA sent providers an email on June 8, 2016 announcing the necessity of completing the upcoming provider assessment. The email also contained a PDF version of the assessment instrument for providers to review and information regarding webinars to assist providers in completing the self-assessments. MDH also sent providers a personalized email on June 13, 2016 after an informational webinar announcing the opening of the self-assessment. Included in this email were the provider's medical assistance number, DDA

license number and site numbers, and instructions to enter the numbers into the provider's self-assessment(s).

Webinars held on June 12 and 13, 2016 walked providers through the assessment and helped answer questions. Providers were further instructed to complete self-assessments for each site operated.

Providers with 40 or fewer sites were instructed to complete all of their site assessments by July 31, 2016 and providers with over 40 sites were instructed to complete all of their site assessments by August 31, 2016. However, the assessment remained open until the morning of November 7, 2016.

One hundred thirty-four providers completed assessments for each site operated, totaling 1,964 completed assessments. The maximum number of assessments completed by a provider was 75, while the minimum was 1. The average number of assessments completed by a provider was 15. The plurality of the service settings are alternative living units, which account for 64 percent of the completed assessments. The Hilltop Institute "HCBS Final Rule: DDA Residential Provider Self-Assessment Summary" November 22, 2016 full report can be viewed on the MDH website.

Provider Transition Plans

The Department sought input from the DDA Transition Advisory Team on a standardized Provider Transition Plan template, instructions, guidance, and development of a reconsideration request process. The Provider Transition Plan template was prepopulated with concerns/issues for specific sites based on the provider's responses to the survey questions and Medicaid's compliant/non-compliant coding scheme. Any provider who felt that they misunderstood the question(s) or that Department misunderstood their response(s) had the opportunity to submit a request for reconsideration within 10 days. The Provider Transition Plan guidance and supporting documents can be viewed on the MDH website. Providers had up to 90 calendar days to submit their Provider Transition Plan which included transitional codes to assist with organizing and reviewing and details of the provide specific transitional strategies.

PARTICIPANT ASSESSMENTS

MDH will be using the Community Setting Questionnaire (CSQ) approved by CMS under the Community First Choice program for all waiver programs, including the Community Pathways program. See Appendix 12 for the day program CSQ and Appendix 13 for the residential program CSQ.

DDA's Coordinators of Community Services (case managers) will administer the CSQ during quarterly monitoring visits and enter into a database so a comparison can be made between the participant questionnaire and the provider self-assessment.

The CSQ will then be conducted annually or with any chance in service settings. The CSQ is also being incorporated into Maryland LTSS tracking system to support ongoing monitoring. System implementation is scheduled for 2018.

The CSQs will also be used as one strategy to validation provider self-assessments and gather information about the setting. It is not a participant experience or satisfaction survey. The Department will work with the DDA Transition Advisory Team to explore strategies to use the new person-centered plan and relevant discovery focus areas for assessing ongoing compliance.

Site Specific Assessment

Based on the results of the preliminary data analysis and statewide provider survey, Maryland will identify specific licensed sites that will need further review prior to the completion of a comprehensive setting results document in order to validate the information obtained through the comprehensive survey.

Validation of the compliance of the specific sites will be determined by CMS guidance as to what is and is not a community setting. CMS has issued clear guidance that any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS is presumed to have the qualities of an institution. Maryland, with the assistance of The Hilltop Institute and stakeholders, will utilize this guidance in developing and establishing criteria for engaging in site-specific assessments. Results of the site-specific assessments will be used to identify specific settings that do not meet the HCB setting requirements. Site visits will be coordinated by the DDA during the months of July through December 2017.

DDA Rate Study

As per Maryland legislation passed last year, Chapter 648 of the Acts of 2014, the DDA procured a contractor to conduct an independent cost-driven rate setting study, develop a strategy for assessing the needs of individuals receiving services, develop a sound fiscal billing and payment system, and obtain input from stakeholders including individuals receiving services and providers. This rate setting process will look at all current and proposed new services. The anticipated duration of services to be provided under this contract is an eighteen-month base period and two one-year option periods. During the initial eighteen- month performance period, the contractor will define the rates and provide a fiscal impact analysis. The option periods will be exercised if implementation support is required.

Comprehensive Setting Results of the DDA Service Delivery System

Maryland will develop a comprehensive setting results document, which identifies and publically disseminates the DDA service delivery system's level of compliance with HCB setting standards. The data gathered from the comprehensive setting results document will be utilized to begin the process of correction and implementation of the necessary remedial strategies.
Maryland will develop a comprehensive setting results document which identifies the number of DDA settings that:
•Fully comply with the HCB setting requirements;
•Do not meet the HCB setting requirements and will require modifications; and
•Are presumptively non-home and community-based but for which the State will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings for CMS' heightened scrutiny process.

DDA Oversight Process/Quality Assurance To Ensure Continuous Compliance With HCB Setting Criteria

<u>DDA Transition Advisory Team</u>

The DDA Transition Advisory Team (TAT) was established to provide information and guidance to the MDH related to strategies associated with the State Transition Plan due to the unique needs of individuals with developmental disabilities, the DDA provider service delivery network, and historical practices. The group includes program participants, family members, self-advocates and representation from various stakeholder organizations such as: People on the Go (self-advocacy organization), the Maryland Developmental Disabilities Council, the Maryland Center for Developmental Disabilities, the DDA Quality Advisory Council, the Disability Rights Maryland (formerly the Maryland Disability Law Center), The Arc of Maryland, the Coordination of Community Services Coalition, and the Maryland Association of Community Services (MACS) (provider association). This group provides recommendations and guidance on stakeholder input, remediation strategies, and action items from the transition plan. Meeting minutes will reflect the recommendations at each meeting.

TIERED STANDARDS

The DDA established a stakeholder group to assist with the development of Tiered Standards. Tiered Standards provides an opportunity for Maryland to develop best practices and new innovative service delivery models, as the current service models were developed in 1986. Four subgroups were formed related to Employment and Day Services, Residential Services, Training, and Finance. Recommendations from these subgroups can be viewed on the MDH website. New standards may establish or promote new or existing models of service that more fully meet the DDA's vision and priority focus areas including self-direction, self-determination, employment, supporting families, and independent supported housing. Once finalized, the standards will be incorporated into a waiver amendment. Current day and residential settings currently in use in the Community Pathways waiver may continue within the waiver, as long as they will be able to meet the minimum standard set in the rule on or before the end of the transition period. The DDA may suspend admission to the setting or suspend new provider approval or authorizations for those settings based on the establishment of Tiered Standards.

HEIGHTENED SCRUTINY

Maryland will require heightened scrutiny for the following settings, but not limited to:

- Sheltered workshops
- Farmsteads
- Licensed residential sites in close proximity (e.g. next door or multiple homes on a cul-de-sac)

Maryland will identify settings that may appear to have qualities of an institution or appear to be isolating individuals from the community but have been determined to meet the community settings requirements. MDH's heighten scrutiny reviews will consist of:

- A review of person-centered support plans and Community Setting Questionnaire for individuals receiving services in the setting
- Interviews with service recipients
- A review of data pertaining to services utilized by persons receiving services in the specified setting
- An on-site visit and assessment of physical location and practices
- A review of policies and other applicable service related documents
- Additional focused review of the agency's proposed transition plan as applicable including how each of the above is expected to be impacted as the plan is implemented
- State determination regarding:
    - Whether the setting in fact is "presumed to have the qualities of an institution" as defined in rule/guidance
    - Whether the presumption is overcome based on evidence
- Collection of evidence to submit to CMS to demonstrate compliance

MARYLAND'S TRANSITION REMEDIATION STRATEGIES

It is important to note that the intent of the transition plan and remediation strategies is not to close or terminate providers but instead, to work with participants, providers and other stakeholders to come into compliance with the CMS Final Rule and the vision of ensuring individuals are fully integrated into the community, afforded choice, and have their health and safety needs met. The table below outlines the strategies that Maryland has developed to both further assess compliance and to then address areas of non-compliance.

TOPIC: Maryland Law - Maryland will propose legislation changes in order to revise the Developmental Disabilities statute (law) to comply with the new HCB setting rule.
Timeline: 10/2017

Milestone: Legislation
Monitoring: DDA Quality Advisory Council
Remediation Strategy:
1. Maryland to complete crosswalk the developmental disabilities statute (law) with the HCB rule requirements. Timeline: 10/2017
2. Stakeholder input on preliminary findings. Timeline: 5/2015
3. Legal Review of preliminary findings. Timeline: 6/2015
4. Develop legislative bill. Timeline: 7/2017
5. Submit for Legislative process. Timeline: 10/2017

TOPIC: Regulations - Maryland will review and revise all applicable program regulations to meet the new HCB settings rule.
Timeline: 10/2017
Milestone: Adopted Regulations
Monitoring: Office of Health Services and established stakeholder transition teams
Remediation Strategy:
1. Maryland to complete crosswalk of program regulations. Timeline: 12/2014
2. Legal Review of preliminary findings. Timeline: 6/2015
3. Develop regulation revisions to comply and allow for enforcement of HCB rule. Timeline: 12/2016
4. Stakeholder process and public notice to amend regulations. (CP, HCBOW, Med Day) Timeline: 6/2017
5. Develop regulation revisions to comply and allow for enforcement of HCB rule. (Remaining regulations) Timeline: 8/2017
6. Stakeholder process and public notice to amend regulations. (Remaining regulations) Timeline: 1/2018

TOPIC: Transition Advisory Teams - Creation of transition teams specific to the unique program service delivery system and/or service provider for ongoing stakeholder guidance, input, and monitoring of transition plan remediation. Teams will include program participants, family members, self-advocates and representation from other stakeholders.
Timeline: 4/2015
Milestone: Transition Teams
Monitoring: Office of Health Services and established stakeholder transition team
Remediation Strategy: Establishment of the DDA Transition Team. Timeline 4/2015

TOPIC: Community Pathways Waiver Review - To further assess and enhance the DDA services delivery system, the DDA has procured independent consultants to review the Community Pathways Waiver for compliance with the Community Settings Final Rule.
Timeline: 4/2015
Milestone: Consultant Report
Monitoring: DDA Quality Advisory Council
Remediation Strategy: Independent consultants review of the Community Pathways Waiver. Timeline 4/2015

TOPIC: Maryland's Community Supports Standards - Communicate Maryland's HCB settings vision, expectations, and standards in compliance with the CMS rule to all stakeholders.
Timeline: 4/2015
Milestone: Department Transmittal, Group Home Moratorium, Group Home Moratorium Clarification
Monitoring: Office of Health Services and established transition team
Remediation Strategy: MDH to issue formal statement regarding HCB setting vision, expectations, and standards in compliance with the CMS rule. Timeline: 4/2015

TOPIC: Lease or Other Legally Enforceable Agreement – Service providers use different leases or

residency agreements for the service they provide. Maryland will request a representative sample of leases or residency agreement to assess for compliance with the Community Settings Final Rule.
Timeline: 12/2018
Milestone: Lease and Residency Agreements Summary
Monitoring: OHS and established transition team
Remediation Strategy:

1. Collect and assess provider lease or residency agreement to determine if they are legally enforceable and comply with Final Rule. Timeline: 5/2015
2. Explore standard lease or agreement for specific service delivery system. Timeline: 6/2015
3. Work with the stakeholders and Maryland Disability Law Center and Legal Aid to explore local county requirements and propose recommendations to be reviewed by the public and implemented across the similar programs. Timeline: 6/2016
4. Regulation requirement in COMAR Fall 2017
5. Communicate standards with participants and providers. Timeline: 12/2017
6. Providers come into compliance with lease agreement requirements. Timeline: 12/2018
7. Maryland assesses ongoing compliance by reviewing all leases and residency agreements of all new providers and a randomly selected, statistically significant sample of existing providers annually. Timeline: Ongoing

TOPIC: Initial Participant and Provider Surveys - Based on the results of the preliminary surveys which grouped programs together, Maryland will work with program transition teams to develop waiver (program) specific comprehensive surveys that will provide data to further assess compliance with the Final Rule. Due to the unique individual needs and provider sites, a survey is to be completed for each licensed site.
Timeline: 6/2015
Milestone: Survey Report
Monitoring: Office of Health Services and established stakeholder transition teams
Remediation Strategy: Develop waiver program specific participant, provider, and site assessments survey techniques and alternative methodologies to determine provider compliance with the HCB setting rule including identifying supports for participants in completing the surveys. Timeline: 6/2015

TOPIC: Provider Transition Symposium - Maryland, in partnership with stakeholders, will conduct a symposium to share communities of practice and transition strategies from Maryland service providers and national entities.
Timeline: 12/2018
Milestone: Provider Transition Symposium
Monitoring: Office of Health Services and established stakeholder transition teams
Remediation Strategy: Provide technical assistance for providers to transition current service delivery system to comply with new HCB setting rule. Timeline: 12/2018

TOPIC: Waiver Amendments - Based on assessment of waiver programs, independent consultant findings, and stakeholder input, amend waiver programs to comply with the Final Rule. To provide time for development of new service models, business processes, rates and stakeholder input, program changes may occur in stages with additional amendments submitted at later dates.
Timeline: 7/2016
Milestone: Waiver Amendment # 1
Monitoring: Office of Health Services and established transition team
Remediation Strategy: Submit Community Pathways Waiver Amendment to CMS

TOPIC: Pilot Waiver Specific Surveys - Prior to implementation of a waiver program specific survey, Maryland will administer the program specific surveys using a pilot group in order to assess the validity and reliability of the survey.

Timeline: 1/2015
Milestone: Pilot Survey Summary
Monitoring: Office of Health Survey and established transition team
Remediation Strategy: Piot program surveys for participants and providers.

TOPIC: Provider Enrollment and Provider Training - Review and revise, as needed, the program provider enrollment and recertification processes. Provide training to new and existing providers to educate them on the new HCB settings requirements, provider transition plans, and State actions for noncompliance.
Timeline: 1/2016
Milestone: Revised Provider Enrollment Process and Provider Training
Monitoring: Office of Health Services and established transition team
Remediation Strategy: Review and revise provider enrollment and provide training as applicable. Timeline: 1/2016 and Ongoing

TOPIC: Participant and Provider Surveys - Once the pilot surveys have been validated, Maryland, with the advice from program transition teams, will implement system wide surveys for participants and providers. The Hilltop Institute will analyze the data and provide a report on the survey results for each waiver program. The results will be shared with stakeholders throughout the systems.
Timeline: 1/2017
Milestone: Survey Results Summary
Monitoring: Office of Health Services and established transition team
Remediation Strategy:

1. Conduct waiver program specific participant and provider surveys to determine compliance with the Final Rule. Timeline: 1/2017
2. Maryland intends to suspend provider numbers of the providers who fail to complete the survey after two requests. Providers will be informed of this in the introduction letter and through transmittal to providers. Telling the provider that the State will assume that they are not in compliance if they do not respond, and make a plan for relocation. Timeline: Ongoing

TOPIC: DDA Provider Transition Plans - Maryland's program administering agencies will provide technical assistance for providers whom have been identified as non-compliant with the rule. Stakeholder transition teams will provide guidance on remediation processes and format of provider transition plans. Providers interested in continuing to providing services shall develop transition plans to comply with the Final Rule. Plans will be reviewed and monitored for implementation by the applicable program's administering agency.
Timeline: 3/2018
Milestone: Provider Training and Provider Transition Plans
Monitoring: DDA (Program Administering State Agencies)
Remediation Strategy:

1. Maryland to develop and provide training for providers on requirements of transition plans. Timeline: 7/2017
2. Providers to develop transition plans to come into compliance with Final Rule. Timeline: 12/2017
3. Program administering agencies to provide technical assistance, approve or deny plan, and monitor implementation (as applicable). Timeline: 3/2018

TOPIC: DDA Rate Study - As per legislation recently passed, Chapter 648 of the Acts of 2014, the DDA procured a contractor to conduct an independent cost-driven rate setting study, develop a strategy for assessing the needs of individuals receiving services, develop a sound fiscal billing and payment system, and obtain input from stakeholders including individuals receiving services and providers. The analysis must adhere to all "Relevant Regulations Regarding DDA Rates" as well as with the CMS Final Rule, and should seek to maximize federal match during and post implementation.

Timeline: 12/2017
Milestone: Rate Study Report
Monitoring: DDA
Remediation Strategy: Conduct rate study of DDA services and payment system to define the rates and provide a fiscal impact analysis. Note: During the initial 18 month performance period, the contractor will define the rates and provide a fiscal impact analysis. There are two one-year options if implementation support is required. Timeline: 12/2017

TOPIC: DDA Tiered Standards - Develop new models of services and standards that more fully meet HCBS standards and Maryland's vision.
Timeline: 12/2016
Milestone: Workgroup Reports
Monitoring: DDA
Remediation Strategy: Create leadership group including individuals, family members, services providers, and advocacy organizations to discuss tiered standards for the Community Pathways waiver. Recommendation to be submitted to DDA. Timeline: 12/2016

TOPIC: Program Policies, Procedures, Service Plans, and Forms - Review and revise all applicable internal and external program policies, procedures, plans, and forms including settings questionnaires to meet the HCB rule.
Timeline: 1/2017
Milestone: Revised forms, and service plans
Monitoring: OHS and established transition team

TOPIC: On-Site Specific Assessment - Based on the results of the preliminary settings inventory, statewide program specific surveys, and stakeholder recommendations, Maryland will identify specific provider sites that will need further review prior to completion of the comprehensive setting results document.
Timeline: 12/2021
Milestone: Site Specific Assessments Summary
Monitoring: Office of Health Services and established transition team
Remediation Strategy:

1. Validation of compliance of the specific sites based on CMS guidance as to what is and is not a community setting and criteria related to settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. Timeline: 12/2021
2. Maryland will do site visits to a randomly selected, statistically significant sample of providers of all types. Maryland will also do a participant survey using the community settings questionnaire and complete site visits to all sites where there is a discrepancy between the provider self-report and participant survey. Timeline: Ongoing

TOPIC: Heightened Scrutiny - Maryland will identify settings that may appear to have qualities of an institution or appear to be isolating individuals from the community but have been determined to meet the community settings requirements.
Timeline: 3/2018
Milestone: CMS Approval Decision
Monitoring: Office of Health Services
Remediation Strategy: A review supporting documentation to justify meeting community settings requirements. Interviews with service recipients. Conduct on-site visit and assessment of physical location and practices. State determination. Collection of evidence to submit to CMS to demonstrate compliance. Submit to CMS. Timeline 3/2018

TOPIC: Comprehensive Settings Results Report - Maryland will develop a comprehensive setting results document, which identifies program-specific level of compliance with HCB settings standards. This document will be disseminated to stakeholders throughout the system.
Timeline: 12/2021
Milestone: Comprehensive Settings Results Report
Monitoring: Office of Health Services and established transition team
Remediation Strategy: Comprehensive settings results report will be shared with stakeholders to begin the process of systemic and provider transitions for compliance. Timeline: 12/2021

TOPIC: Provider Disenrollment – In the event a provider either choose not to transition or has gone through remediation activities and continues to demonstrate noncompliance with HCB setting requirements, the State will develop a specific process for i provider disenrollments.
Timeline: 3/2022
Milestone: Disenrollment Summary
Monitoring: Program Administering State Agency
Remediation Strategy: Maryland will disenroll providers that fail to meet remediation standards and HCB settings requirements. Timeline: 3/2022

TOPIC: Participant Transitions - When providers are dis-enrolled, participants will be assisted by their person-centered team in exploring new provider options. When a participant must relocate, the State, or its designated agent, will provide:

1. Reasonable notice to the individual and due process;
2. A description of the timeline for the relocation process; and
3. Alternate setting that aligns, or will align, with the regulation, and that critical services/supports are in place in advance of the individual's transition.

The State will report the number of participants impacted.
Timeline: 01/2022
Milestone: Relocation Process
Monitoring: Office of Health Services and established transition team
Remediation Strategy: Develop description of the Maryland's process to assure that participants, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice for relocation. Timeline: 01/2022

TOPIC: Ongoing Compliance and Monitoring – Quality reviews and verification of ongoing provider compliance with the Final Rule will be assessed by the program administering agency and its agents such as the Office of Health Care Quality. Maryland to explore common assessment indicators such as settings questionnaire, NCI, and existing experience survey.
Timeline: Ongoing
Milestone: Quality Reports
Monitoring: Office of Health Services and Program Administering State Agency
Remediation Strategy:

1. Review quality indicators/tools being used in waiver programs currently. Timeline: 12/2017
2. Look to standardize quality measures across programs. Timeline: 6/2018
3. Assess ongoing compliance with Final Rule by providing technical assistance as needed, and take appropriate action to remediate, sanction, or dis-enroll. Timeline: Ongoing
4. Ensuring 100% compliance providers will be assessed annually with the completion of the community settings questionnaire. Timeline: Ongoing
5. In addition to the community settings questionnaire the State will also complete site visits to a randomly selected, statistically significant sample of providers of all types. In all settings that there is a discrepancy between the provider self-report and the participant survey, a site visit will also be

completed. Timeline: Ongoing

SECTION 3: PUBLIC INPUT AND COMMENT (Abbreviated due to space limitation)
Maryland is committed to sharing information and seeking public input into the State's assessment for compliance with the Final Rule and the development and implementation of this transition plan. In October 2014, the OHS and DDA established dedicated webpages related to the rule. The webpages have links to both internal and external sites including the CMS website and the Association of University Centers on Disabilities (AUCD) HCBS Advocacy site. The website includes the initial self-assessment surveys, printable versions and links to the online survey, lists of questions and responses from all regional and webinar presentations, and contact information, both a phone number and devoted email address for questions. The OHS site is located at:
https://mmcp.health.maryland.gov/waiverprograms/Pages/Community-Settings-Final-Rule.aspx
~~https://mmcp.dhmh.maryland.gov/waiverprograms/SitePages/Community%20Settings%20Final%20Rule.aspx.~~

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

⊙	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	⊙	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/ unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	**Developmental Disabilities Administration (DDA)**
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

The Maryland Department of Health (MDH) is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's Office of Health Services (OHS) is the Medicaid unit within the SMA that oversees the Community Pathways Waiver. In this capacity, OHS oversees the performance of the Developmental Disabilities Administration (DDA), Operating State Agency (OSA) for the waiver. The OHS serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support from DDA.

The DDA is responsible for the day-to-day operations of administering this waiver, including but not limited to enrolling participants into the waiver, reviewing and approving community-based agencies and licensure applications for potential providers, monitoring claims, and assuring participants receive quality care and services based on the assurances requirements set forth in this waiver. The DDA is

responsible for collecting, trending, prioritizing and determining the need for system improvements.

OHS will meet regularly with DDA to discuss waiver performance and quality enhancement opportunities. Furthermore, the DDA will provide OHS with regular reports on program performance. In addition, OHS will review all waiver-related policies issued. OHS will continually monitor DDA's performance and oversight of all delegated functions through a data-driven approach. If any issues are identified, OHS will work collaboratively with DDA to remediate such issues and to develop successful and sustainable system improvements. OHS and the DDA will develop solutions guided by waiver assurances and the needs of waiver participants. OHS will provide guidance to DDA regarding recommended changes in policies, procedures, and systems.

A detailed Interagency Agreement (IA) outlines the roles and responsibilities related to waiver operation and those functions of the division within OHS with operational and oversight responsibilities.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Not applicable

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (s*elect one)*:

⊙	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas: (1) Participant Waiver Applications; (2) Support Intensity Scale (SIS)®; (3) Quality Assurance; (4) System Training; (5) Research and Analysis; (6) Fiscal Management Services (Agency with Choice); (7) Health Risk Screening Tool; (8) MD-Long Term Services and Supports Information System; and (9) Behavioral and Mental Health Crisis Supports. 1. Participant Waiver Application The DDA contracts with independent community organizations and local health departments as Coordinators for Community Services to perform intake activities, including taking applications to participate in the waiver and referrals to county, local, State, and federal programs and resources. 2. Support Intensity Scale (SIS)® The DDA contracts with an independent community organization to conduct the Support Intensity Scale SIS®. The SIS® is an assessment of a participant's needs to support independence. It focuses on the participant's current level of support needs instead of focusing on skills or abilities they may not currently demonstrate. The Coordinators of Community

	Service use each completed SIS® as a planning guide in the development of the participant's Person-Centered Plan. 3. Quality Assurance The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys. The DDA will be contracting for a Quality Improvement Organization–like organization to support administrative functions related to technical assistance, quality assurance, and utilization review. 4. System Training The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (i.e. person-center planning), health and welfare (i.e. choking prevention), and workforce development (i.e. alternative communication methods). 5. Research and Analysis The DDA contracts with independent community organizations and higher education entities for research and analysis of waiver service data, trends, options to support waiver assurances, financial strategies, and rates. 6. Fiscal Management Services The DDA contracts with independent community organization for fiscal management services to support participants that are enrolled in the DDA's Self-Directed Services Model, as described in Appendix E. 7. Health Risk Screen Tool The DDA contracts with Health Risk Screening, Inc. for training and the use of an electronic Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs and training. 8. LTSS Maryland - Long Term Services and Supports Information System The MDH contracts with information technology organizations for design, revisions, and support of the database that supports waiver operations. 9. Behavioral and Mental Health Crisis Supports The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during behavioral and mental health crisis. 10. Organized Health Care Delivery System providers Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community agencies and entities that are not Medicaid providers. The OHCDS provider's administrative for the action is not charged to the participant.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select one)*:

⊙	**Not applicable**
○	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DDA has a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which the DDA enters.

Standard practice includes assignment of a contract monitor to provide technical oversight for each agreement, including specific administration and operational functions supporting the waiver as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

DDA staff monitor each agreement and assess contract performance on an ongoing basis, depending on the specific contract requirements, but no less frequently than annually.

1. Participant Waiver Application – DDA reviews all applications for completeness as per DDA policy and provide technical assistance, training, or request corrective action as needed.

2. Support Intensity Scale (SIS)® - DDA's contract monitor reviews submitted invoices and documentation related to completed Support Intensity Scale SIS®. Corrective actions are taken for discrepancies.

3. Quality Assurance – DDA's contract monitor reviews submitted data with the National Core Indicator (NCI) Reports and initiates corrective actions as needed.

4. System Training – DDA staff review supporting documentation including attendance sheets prior to approval of invoices.

5. Research and Analysis – DDA staff review activity reports and supporting documentation prior to service delivery.

6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks and provide technical assistance, training, or request corrective action as needed.

7. Health Risk Screen Tool – DDA's contract monitor reviews submitted invoices and documentation related to completed HRSTs. Corrective actions are taken for discrepancies.

8. LTSS Maryland - Long Term Services and Supports Information System – DDA staff review and authorize service deliverables based on work orders.

9. Behavioral and Mental Health Crisis Supports - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract. Corrective actions are taken for discrepancies.

10. Crisis hotline services, mobile crisis services, and behavioral respites services - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract. Corrective actions are taken for discrepancies.

11. Organized Health Care Delivery System providers - DDA audits service providers for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

Assessment results will be shared with OHS during monthly meetings.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☑	☐
Level of care evaluation	☑	☐	☑	☐
Review of Participant service plans	☑	☑	☑	☐
Prior authorization of waiver services	☑	☐	☐	☐
Utilization management	☑	☐	☐	☐
Qualified provider enrollment	☑	☐	☐	☐
Execution of Medicaid provider agreements	☑	☐	☐	☐
Establishment of a statewide rate methodology	☑	☐	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☑	☐
Quality assurance and quality improvement activities	☑	☐	☑	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..

i Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- ***Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver***
- ***Equitable distribution of waiver openings in all geographic areas covered by the waiver***
- ***Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).***

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:	*AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the OHS, in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports received by the OHS.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: DDA Quality Report	

	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*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Performance Measure:	*AA - PM2: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D = # of providers*
Data Source *(Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions*	
If 'Other' is selected, specify:	

	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*
	☐ *Sub-State Entity*	☑ *Quarterly*	☐ *Representative*

				Sample; Confidence Interval =
	☐ Other Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Performance Measure:	*AA - PM3: Number and percent of waiver policies approved by the OHS. N = Number of waiver policies approved by the OHS D = Total number of waiver policies issued.*
Data Source *(Select one) (Several options are listed in the on-line application): Presentation of policies or procedures*	
If 'Other' is selected, specify:	

	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*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☑ Annually*	
		☑ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Performance Measure:	*AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meeting scheduled during the fiscal year.*
Data Source *(Select one) (Several options are listed in the on-line application):Meeting Minutes*	
If 'Other' is selected, specify:	

	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*
	☐ Sub-State Entity	*☑ Quarterly*	*☐ Representative*

				Sample; Confidence Interval =
	☐ Other Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Performance Measure:	*AA - PM5: Number and percent of Type 1- Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OHS. N = # of Type 1 - Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OHS. D = Number of Type 1 - Priority A incidents of abuse, neglect or exploitation reviewed by the OHS.*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify: PCIS2 PORII Module			
	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*
	☐ Sub-State Entity	*☑ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☑ Other Specify: Office of Health Care Quality	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Performance Measure:	*AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ the met requirements. D = # of on-site death investigations reviewed by the OHCQ*		
Data Source *(Select one) (Several options are listed in the on-line application)Record Review, on site*			
If 'Other' is selected, specify:			
	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*
	☐ Sub-State Entity	*☑ Quarterly*	*☐ Representative Sample; Confidence Interval =*

	☐ *Other Specify:*	☐ *Annually*		
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *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.*

b. Methods for Remediation/Fixing Individual Problems

i *Describe the State's 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.*

The Office of Health Services (OHS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements. To this end, OHS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to OHS. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OHS, upon review of the report, will meet with DDA to address problems and barriers. Guidance from OHS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. OHS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, OHS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with OHS exercising ultimate authority to approve such solutions.

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*
	☐ *Sub-State Entity*	☑ *Quarterly*
	☐ *Other Specify:*	☐ *Annually*
		☐ *Continuously and*

[redacted]		*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 Administrative Authority that are currently non-operational.

☑	**No**
○	**Yes**

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