Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

(a) **Requirements concerning the independent audit of provider agencies**

In accordance with the Maryland Annotated Code Health General Article Title 7 and Code of Maryland Regulations (COMAR) 10.22.17.05, all DDA licensed providers are required to submit on an annual basis: (1) a cost report documenting the provider's actual expenditures for the fiscal year being reported; (2) audited financial statements supporting the cost report; (3) a worksheet reconciling the cost report to the financial statement; and (4) a certification by an independent certified public accountant, who is not an employee of the licensed provider or any affiliated organization, that he or she prepared the cost report and financial statement.

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

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

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

3. Office of the Inspector General
The Maryland Department of Health, Office of the Inspector General, conducts audits of DDA contractual services. The objectives of these audits are:

1. Determine the amount of program revenue received and allowable expenditures incurred by the program for the DDA contracts;
2. Determine any amount due to the State or to the provider resulting from the operation of the program during the audit period:
3. Determine to the extent possible that financial matters were conducted in accordance with the Department of Health's Human Services Agreement Manual (HSAM); and,
4. Provider recommendations for improving internal controls, ensuring fiscal compliance, or

increased efficiency.

4. Utilization Review

The DDA is hiring a Contractor to conduct post payment reviews of claims to ensure the integrity of payments made for Waiver services. The utilization reviews are to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for are being provided to the participant. The reviews consist of reviewing provider furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the Person Centered Plan (PCP) or Service Funding Plan (SFP).

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

The Contractor will conduct a remote audit of the provider, requesting and reviewing information, including: staff notes and logs for the consumer(s) identified in the remote audit; the provider's staffing plan, timesheets, payroll records and receipts; and any other documentation required by MDH. The Contractor will prepare a preliminary audit report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the PCP.

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

a) Less services provided than billed;
b) Less or more service provided than authorized in PCP (+/- >14%);
c) Services provided did not match the definition of services billed;
d) Staff qualifications could not be confirmed in the remote audit or the individual providing service was not appropriately qualified; and
e) Payments that cannot be substantiated by appropriate service record documentation

For the targeted audit, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's PCP. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the consumer receiving services, and/or the participant's family or legal guardian and Coordinator of Community Services, as appropriate.

The Contractor shall prepare a summary of the audit findings and will hold an exit interview in person with the provider to verbally share a synopsis of their findings. This will be followed up by a formal letter of findings and allowing for the provider to provide input.

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

The DDA Provider Relations staff in the regional offices handle follow-up of corrective action plans, if

any is required. The DDA Fiscal Unit will pursue any financial recovery owed to the State.

Quality Improvement: Financial Accountability

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

i. Sub-assurances:

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

a.i. Performance Measures

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

Performance Measure:	FA - PM1 Number and percent of claims that are supported by documentation that services were delivered. Numerator = number of claims reviewed that are supported by documentation. Denominator = number of claims reviewed.
Data Source *(Select one) (Several options are listed in the on-line application):* MMIS Reports and PCIS2	
If 'Other' is selected, specify MMIS claims data; participant records	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =95% +/- 5%*

	X Other Specify: Utilization Review Contractor	*X Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		Other Specify:`		
				☐ Other Specify:

Performance Measure:	FA – PM2 Number and percent of claims paid for participants who are eligible on the date the service was provided and where services were consistent with those in the service plans. Numerator = Number of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. Denominator = Number of claims paid reviewed.
Data Source *(Select one) (Several options are listed in the on-line application):*MMIS Reports, PCIS**2**	
If 'Other' is selected, specify: MMIS claims data; PCIS2 or LTSS data	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =95% +/- 5%*
	X Other Specify: Utilization Review Contractor	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			Other Specify:

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

Performance Measure:	FA PM3 Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims paid reviewed.
Data Source *(Select one) (Several options are listed in the on-line application):* MMIS Reports, PCIS**2**	
If 'Other' is selected, specify: MMIS claims data and PCIS**2** or LTSS	

	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)*
	X State Medicaid Agency	*☐ Weekly*	*100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =95% +/- 5%*
	X Other Specify: Utilization Review Contractor	*X 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.

PM1 – DDA or the Utilization Review Contractor will review a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

PM2 - The reimbursement logic built into MMIS, PCIS2, and LTSS will ensure that waiver participants are eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, DDA fiscal staff, or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into MMIS, PCIS2, and LTSS will ensure that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, DDA fiscal staff or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the reimbursement rate.

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.*

PM1- Number and percent of claims that are supported by documentation that services were delivered.

If DDA fiscal staff or the Utilization Review Contractor finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by DDA and the Department may initiate an expanded review or audit. If indicated, DDA will work with Provider Relations and/or the Utilization Review Contractor to conduct further claims review and remediation activities as appropriate. The provider may be requested by Provider Relations to submit a corrective action plan that will specify the remediation action taken. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, and voiding (and/or recovering) payments, if the situation warrants. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

PM2- Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with PCIS2 staff and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, DDA will adjust the claims accordingly and in a timely manner.

PM3- Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:***

(including trend identification)		*(check each that applies)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	√ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	√ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

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

✓	**No**
	Yes

APPENDIX I-2: Rates, Billing and Claims

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

The rate methodologies for Community Pathways Waiver Fee Payment System (FPS) services will vary in Waiver Years 1 and 2 as DDA transitions from a prospective payment system to a reimbursement model. Simultaneously DDA will also transition from the current standalone platform, PCIS2, to the Medicaid Long Term Services and Supports system, or LTSS. New proposed rates from the rate study completed this year will be used for non-FPS services but will not be used for FPS services until DDA transitions both the payment model and the IT system in Waiver Year 2.

In accordance with Maryland law (Chapter 648 of the Acts of 2014), the DDA procured a contractor, Johnston, Villegas-Grubbs & Associates (JVGA), to conduct an independent cost-driven rate setting study and obtain input from stakeholders, individuals receiving services, and providers of the services. The proposed rates were to meet the requirements of the Social Security Act that they be "consistent with efficiency, economy, and quality of care and efficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."

JVGA developed the Brick Method ™, which is a structure used to develop standard fees for disability (and other services) that utilizes cost categories and studies their relationship to direct service support costs (the wages of people performing the service). The foundation of the Brick is the direct support professional wage. JVGA established wage levels from the Bureau of Labor

Statistics (BLS).

Included in the rates are four standard cost components that are assumed to be common to all social and medical services. They are employment related expenses, program support, facility cost (day habilitation only) and general and administrative. In Maryland, training and transportation components were also studied and used to develop the rates. JVGA surveyed and analyzed the general ledgers of around 70 DDA providers to standardize the cost component and rates. The Rate Study report was released on November 3, 2017. The contractor will be conducting town hall meetings from November 13 to 16, 2017 in each of the 4 regions in Maryland. The Rate Study Report and the rates are published on DDA's website at https://dda.health.maryland.gov/Pages/home.aspx. Any changes to current service rates covered under this program will be updated with a waiver amendment.

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

Fee schedule service rates include the following:

Behavioral Support Services- The rates for Behavioral Assessment and Behavioral Consulting are based on the BLS hourly wage data for a Psychologist or Other PhD with the productivity assumption of 8 hours for the Assessment and including the cost components: Employment Related Expenditures at 32.7%, Program Support at 33%, Training expenditures at 13.4%, and administrative costs at 11%. The rates for the Behavioral Plan and Brief Support Implementation Services are based on the hourly wage of Clinical, Counseling & School Psychologists and including cost components Employment Related Expenditures at 32.7%, Program Support at 33%, Training expenditures at 13.4%, and administrative costs at 11%. The productivity assumption is 8 hours for the Plan and the hourly rate for Brief Support Implementation is converted to a 15 minute rate.

Employment Services- Follow-Along, On-going Job Supports and Co-Worker Employment Supports rates are based on hourly BLS wage job code 21-1093, Social & Human Services Assistants and include the cost components: 32.7% ERE, 35.6% Standard PS, 5.8% Training, 11% G&A, and 13.7% Transportation. Follow-Along Supports rate assumes a 5% No Show factor and 6 hours a month. On-going Job Supports rate assumes a 5% No Show factor and is an hourly rate. Co-Worker Employment Supports rate based on the hourly rate is limited to a milestone payment of $500 a month.

Employment Services- Discovery, *Job Development and Self-Employment Services* rates are based on hourly BLS wage job code 21-1012, Educational Guidance & Vocational Counselors and include the cost components:32.7% ERE, 35.6% Standard PS, 11.6% Training, 11% G&A, and 13.7% Transportation. The self-employment plan assumes four hours and job development is billed using an hourly rate. Discovery is a milestone service that assumes 10 hours to complete each of the three milestones.

Environmental Assessments - The rate for Environmental Assessments is based on hourly wage data from the Bureau of Labor Statistics data for Occupational Therapists with a productivity assumption of 6 hours and including cost components Employment Related Expenditures at 32.7%, Program Support at 33%, Training expenditures at 13.4%, and administrative costs at 11%.

Family and Peer Mentoring - Family and Peer Mentoring is a new service and the rate is based on a similar service provided in Arizona's Raising Special Kids program and applying Maryland cost values. To calculate the rate for Family and Peer Mentoring, JVGA recommended a wage level based on BLS job descriptions and wage levels for Maryland and used the program support

percentage calculated for Targeted Case Management. Since this is a new service without any history, JVGA based the percentage of employment related expenses and general and administrative costs on the Arizona Raising Special Kids services.

Housing Support Services- The rate is based on the hourly wage data from BLS for a Life, Physical, and Social Service Tech and includes the cost components Employment Related Expenditures at 32.7%, Program Support at 25.7%, Training expenditures at 8.6%, and administrative costs at 11%.

Medical Day Care- The rate for Medical Day Care is based on the rate established by the Medicaid program.

Personal Supports (beginning Waiver Year 2)-The rate is based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 25.7%, Training expenditures at 8.6%, a 5% no show factor, and administrative costs at 11%. The rate was developed as an hourly rate but will be billed in 15 minute increments.

Respite Care Services - Rates were developed for both hourly and daily respite services. The hourly rate is based on the hourly wage of a Personal Care Aide using the BLS and the cost components Employment Related Expenditures at 32.7%, Training expenditures at 8.6%, Transportation costs at 2%, and administrative costs at 11%. The daily rate is based on the hourly rate with an assumption of 16 hours of services.

Career Exploration- The rate is based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 35.6%, Training expenditures at 5.8%, Transportation costs at 13.7%, a closure factor of 3.6%, and administrative costs at 11%. The rate assumes 6 people per staff for Large Group, 2 people per staff for Small Group, and 10 people per staff for Facility.

Market Rate Services include the following:

Assistive Technology and Services, Environmental Modifications, Live-In Caregiver Supports, Remote Electronic Monitoring, Respite Care Camp, Shared Living Services, Transition Services, Transportation and Vehicle Modifications -Payments for market rate services are based on the specific needs of the participant and the piece of equipment, type of modifications, or service design and delivery method as documented in the PCP and associated Service Funding Plan. For needed services identified in the team planning process that do not lend themselves to an hourly rate (i.e. assistive technology, environmental modifications, etc.), the estimated actual cost, based on the identified need (i.e. a specific piece of equipment) or historical cost data, is included in the participant's service budget. The applicable service definitions and limitations included in the waiver application provide any additional requirements for payment of these services. The Regional Office fiscal staff review provider invoices to ensure costs for market rate services are authorized on an individual's PCP. The rate study established upper pay limits for these services, except for Assistive Technology. The payment limit and any other limiting parameters will be programmed into MMIS to avoid overpayment of these services.

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

Tiered-Rate Services include the following:

Tiered rates are used in the Department's rate setting model to reimburse those services for which the level of provider effort and the intensity of the service are variable based upon the differing support needs of individuals. Rates for tiered services are based on the assumption of the hours of service that a participant requires per day. An acuity adjustment was included in the rates for Day and Licensed Congregate services taking into account costs associated with people that require intensive supports such as enhanced supervision.

In Waiver Year 1, FPS services, or those services whose claims are submitted using PCIS2, will continue to use rates based on the current rate methodology. The new rates for these services will not be adopted until DDA transitions to submitting claims using LTSS. Current rates will continue to be used for: *Community Development Services (formerly Community Learning Services), Community Living Group Home (formerly Residential Habilitation) Services and Retainer Fees, Day Habilitation, Employment Discovery & Customization (ending after Waiver Year 1), Personal Supports, and Supported Employment (ending after Waiver Year 1).*

In 1998, initial rates for the Fee Payment System (FPS) were developed and cover four programs—Community Supported Living Arrangements (now Personal Supports) day, residential, and supported employment. FPS service rates are based on two components – the provider and individual component. The provider component pays a flat rate for Administrative, General, Capital, and Transportation (AGC&T) cost centers. As the FPS rates were developed, this component was arrived at in a cost-neutral manner by bringing all providers to the weighted mean AGC&T as reported on their cost reports.

FPS also covers "add-ons" to accommodate temporary changes in client needs (usually for a period under one year, but can be extended), and one-time supplemental costs for special equipment, assistive technology, accessibility modifications to structures, and other needs that are not covered by Medicaid, private insurance, or any other state or federal health program.

The rates used for FPS services are historical in nature and outlined in COMAR 10.22.17.06 through 10.22.17.13. Daily FPS rates are computed using the following three components:

1) The individual component, which assesses the service needs of the individual as determined by their matrix score using an assessment tool called the Individual Indicator Rating Scale (IIRS). This component also includes regional rate adjustments that increase for certain high-cost areas of the State.

2) The provider component, which accounts for the indirect costs of providing care. These are fixed statewide per diem rates, with separate scales for day and residential programs.

3) The add-on component, addresses additional service needs which were not covered under the IIRS matrix score. Add-ons are negotiated at the regional level with each provider. It is important to note that not all individuals require add-ons, but the majority of individuals do have add-ons included in their FPS rates.

Since the publishing of rates, ongoing amendments to rates have occurred. Prior to State FY2016, rates were evaluated for a Cost of Living Adjustment (COLA). If a COLA was approved by the Maryland Legislature, the Maryland Department of Health's Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget.

The Maryland General Assembly passed legislation in 2014 mandating a 3.5% cost of living adjustment (COLA) for community based services providers beginning in State FY 2016 and continuing until State FY 2019. The 3.5% COLA is applied to all community based services, including Personal Supports.

In Waiver Years 2-5, DDA plans to adopt JVGA's proposed rate structure and rates for the following former FPS services:

Community Development Services- The hourly tiered rates are based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 27.8%, Training expenditures at 8.6%, Transportation costs at 49.1%, a 3.6% closure factor, and administrative costs at 11%. The three tiered rates assume staffing ratios: 1staff to 1 person, 1 staff to 4 people, and 2 staff to 1 person.

Community Living Group Home Services- The daily rates are based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 26.7%, Training expenditures at 8.6%, Transportation costs at 7.2%, 3.6% closure factor, an acuity adjustment, and administrative costs at 11%. The rates assume individuals receiving 4, 10, or 17 hours of care.

Community Living Enhanced Supports- The daily rates are based on hourly BLS wage job code 29-2053, Psychiatric Technicians and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 26.7%, Training expenditures at 8.6%, Transportation costs at 7.2%, an acuity adjustment, and administrative costs at 11%. The rates assume 24 hours a day or 42 hours a day of care.

Day Habilitation- The hourly tiered rates are based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Facility costs of 24.5%, Standard PS of 25.7%, Training expenditures at 8.6%, Transportation costs at 49.1%, a 3.6% closure factor, an acuity adjustment, and administrative costs at 11%. The three tiered rates assume staffing ratios: 1staff to 1, 1 staff to 4, and 2 staff to 1.

New services rate methodology for tiered rates Waiver Years 1-5:

Nursing Services- The quarterly hour rates are based on hourly BLS wage data job code 29-1141, Registered Nurse and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 33%, Training expenditures at 13.4%, a 5% no show factor, and administrative costs at 11%.

Supported Living- The daily rates are based on hourly BLS wage job code 39-9021, Personal Care Aide and the following cost components: Employment Related Expenditures at 32.7%, Standard PS of 25.7%, Training expenditures at 8.6%, a 5% no show factor, and administrative costs at 11%. The rates assume individuals receiving 4, 10, or 17 hours of care.

Self -Directed Services

Support Broker Services and Individual and Family Directed Goods and Services are available for self-direction only and are negotiated market rates. Self-Directed Services participants ("SDS Participants") can establish their own payment rates for approved services in their budgets as they are considered the employer; however these rates must be reasonable and customary. To assist SDS Participants, the DDA has developed A Guide to Reasonable and Customary Rates posted on the DDA website.

In accordance with the findings and recommendations of the rate-setting study, the DDA will continue to review and amend as necessary Community Pathways waiver service rates based on the rate setting methodology for comparable services and based on actual cost.

Promulgation of New Rates and Adjustments in Rates

Rates are available on the DDA website and rate changes are made through the regulatory process which includes publication in the Maryland Register. New services rates and any rate changes are published in the Maryland Register and include a 30-day public comment period as required by law. The last amendment to the rates occurred on or about July 1, 2017. The service rates will be reviewed and updated, as needed, at least every five years as required by CMS.

The Maryland General Assembly passed legislation in 2014 mandating a 3.5% cost of living adjustment (COLA) for community based services for providers beginning in State FY 2016 and continuing until State FY 2019. The 3.5% COLA is applied to all community based services, including Personal Supports.

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

The flow of billings for waiver services based on which service delivery model the participant is enrolled in: Traditional Services Model or Self-Directed Services Model.

Billings under the Traditional Services Delivery Model

For claims with dates of service up to Waiver Year 2, Personal Supports, Day Habilitation Services, Community Development Services (formerly Community Learning Services), Employment Discovery & Customization, Community Living Group Home (formerly Residential Habilitation) Service and Retainer Fees and Supported Employment claims will be submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data collects information on: (1) the services included in the participant's Person-Centered Plan (PCP) that can be billed; (2) the approved services and individualized budget set forth in the Service Funding Plan (SFP); and (3) the services actually rendered by the provider. PCIS2 checks the PCP and SFP against the services actually rendered to ensure that overbilling or billing for services not in the PCP or SFP does not occur.

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

For claims with dates of service up to Waiver Year 2, Behavioral Support Services, Environmental Assessments, Environmental Modifications, Medical Day Care, Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Housing Support Services, Live-In Caregiver Supports, Nursing Services, Participant Education, Training and Advocacy Supports, Remote Electronic Monitoring, Respite Care Services, Shared Living Services, Supported Living

Services, Transition Services, Transportation, Vehicle Modifications and Career Exploration Services will be claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into MMIS. The CMS 1500 is completed by the provider of services and submitted to DDA for review. If the CMS 1500 is consistent with the participant's SFP based on his or her PCP, then the DDA submits the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these service claims electronically to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Beginning in Waiver Year 2, DDA plans to transition from PCIS and the paper billing process to the Long Term Services and Supports system, LTSS. Using LTSS, providers will electronically bill for all Waiver services for participants based on the services and allowable units in their PCPs. The PCPs will be loaded into the LTSS system and will be the basis of provider billings. The LTSS system will interface with MMIS to adjudicate claims and pay providers for rendered services. Edits and limits will be placed in LTSS and in MMIS to prevent overbilling and billing for services that are not authorized or in an individual's PCP.

Billings under the Self-Directed Services Delivery Model

For participants enrolled in the Self-Directed Services Model (as described in Appendix E), the Fiscal Management Service (FMS) provider compares employee timesheets or invoices against the DDA-approved plan and annual budget for processing. For claims that match, the FMS then submits them to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

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

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

		eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

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

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

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

MMIS edits are in place to validate the participant's waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid while consumer eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information is updated on a regular basis. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP. Beginning in Waiver Year 2, claims will be submitted using LTSS. The LTSS system will interface with MMIS to determine participant eligibility before claims are sent. If a participant is determined not to be eligible on a date of service, the claim will not be submitted to Medicaid for payment until eligibility is updated.

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

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claim against the PCP and SFP (under the Traditional Services delivery model) and the DDA-approved annual budget (under the Self-Directed Services delivery model). Please refer to Appendix I-2, subsection b. above for further details about these processes. Beginning in Waiver Year 2, individuals' PCPs will be included in LTSS and providers will only be able to bill for services and units that have been approved and included in the plans.

c) **Verification of Service Provision**

The participant's Coordinator of Community Service (CCS) perform quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the PCP and the SFP for participants enrolled in Traditional Services or the DDA-approved annual budget for participants enrolled in Self-Directed Services Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by DDA (see Appendix I-1). DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1.

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

APPENDIX I-3: Payment

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

√	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

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

√	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
√	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	For participants enrolled in the Self-Directed Services Delivery Model (as described in Appendix E), waiver services are paid by the FMS and then the FMS submits the claim through MMIS.

	DDA provides oversight of the FMS providers by conducting an annual audit. The audit monitors and assesses the performance of the provider including ensuring the integrity of the financial transactions that they perform.
☐	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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

√	**No**. **The State does not make supplemental or enhanced payments for waiver services.**
○	**Yes**. **The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

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

○	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
√	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
	Some local Health Departments provide Respite Care services due to a lack of qualified providers in their area to meet the needs of the participants receiving these services.

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

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

√	**The amount paid to State or local government providers is the same as the amount paid**

	to private providers of the same service.
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

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

√	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

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

○	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
√	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.
	Under the current payment methodology, outlined in COMAR, 10.22.17.10-.13, reassignment may be made to the Developmental Disabilities Administration (DDA). Conditions for participation from COMAR 10.09.026.03 require DDA providers to have a provider agreement in effect with DDA and the Medical Assistance Program. The DDA provider agreements acknowledge the reassignment of Medicaid payments to DDA as under the current payment methodology the DDA prospectively pays the providers for expected expenditures for services and the reassignment permits DDA to recover the outlay for the expenditures. This payment methodology will change when providers begin to bill using LTSS, as they will be paid directly for their services.

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

○	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

√	**Yes**. **The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	a) A potential provider interested in becoming an OHCDS may apply to do so as part of initial licensure or by amending their current license and must meet all regulatory requirements outlined in Code of Maryland Regulations (COMAR) 10.22.20.05. A provider may be designated an OHCDS if they submit a DDA application to become an OHCDS provider, and they are a licensed DDA provider for a DDA Fee Payment System service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly. . b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website. c) The Coordinator of Community Services (CCS) supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an OHCDS, or other providers, such as FMS or direct care staff, under the Self-Directed Services Program. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time d) An OHCDS must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. OHCDS shall enter into a subcontract with each provider of service that contains the scope, frequency, duration, and cost of services to be provided; documents the qualifications of the provider of service; details service termination procedures; is consistent with the participant's PCP, and is executed by all parties to the contract. The OHCDS is required to maintain detailed record on the purchase of services from qualified entities or individuals, including invoices. e) In the OHCDS application, the provider agrees to submit an aggregate annual summary, delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individual's serviced by each subcontractor. The report will be due within 30 days of the close of the State fiscal year. As part of the DDA's quality assurance procedures, the DDA surveys OHCDS providers for their compliance with regulatory requirements, including those requirements governing contracts with qualified providers. f) Billing for OHCDS contract services are completed using the CMS 1500 Form or by direct provider electronic submission in the MMIS system. The DDA and Medicaid

	review all claims submitted. The DDA will monitor and conduct oversight of the OHCDS by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

√	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115f waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

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

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

☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

○		**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
√		**Applicable** *Check each that applies:*
	√	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c: Intergovernmental Transfer nominal amount that has not changed since 1986.
	☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

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

√		**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**
○		**The following source(s) are used.** *Check each that applies.*
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**

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

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

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

	No services under this waiver are furnished in residential settings other than the private residence of the individual.
√	**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

The cost of room and board furnished in residential settings including Community Living – Group Home and Community Living – Enhanced Supports are excluded from rates paid to providers and thus is excluded from all Medicaid claims.

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

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

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

○	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
√	**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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

√	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

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

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

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

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	**Charge**	
	Amount	**Basis**

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**

○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

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

√	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes**. **The State imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: