Maryland
DEPARTMENT OF HEALTH

Developmental
Disabilities Administration

Community Pathways Medicaid Waiver Amendment March 2026 Frequently Asked Questions March 11, 2026

Introduction

These questions were shared with the Developmental Disabilities Administration (DDA) during the public input process. Questions were received through the public input email and during DDA Medicaid waiver amendment webinars.

Some questions were similar. When that happened, they were grouped together so answers could be shared more clearly.

The answers below are based on:

- The **proposed amendment**
- Current program standards in the approved waiver

DDA is **seeking input from stakeholders**. This includes ideas, concerns, and alternative recommendations.

More information about the proposal, webinars, and public input process is available on the Community Pathways Amendment #4 2026 webpage.

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Questions About the $500,000 Budget Cap

1. **Does the $500,000 person-centered plan budget cap include all services?**

   Yes.

   The $500,000 budget cap includes the total cost of services in a person-centered plan, including:
   - Residential services
   - Day and employment services
   - Other waiver services

2. **Is there a way to go over the $500,000 budget cap?**

   Yes.

   There is an **exception process** for plans that need more than $500,000.

   The exception process is used when additional supports are **needed to protect a person's health and safety** within waiver service limits.

   Plans that meet the exception standards **may go above the $500,000 cap.**

3. **When would the budget cap start?**

   The proposed effective date is July 1, 2026.

4. **When will DDA review plans that go over the cap?**

   Plans that exceed the cap will be reviewed between March and June 2026.

   During this time, DDA will conduct a quality review and provide technical assistance to participants and their teams.

   Technical assistance may include ensuring that:
   - Service needs are clearly documented
   - Service needs are clearly communicated
   - Services are as cost-effective as possible

5. **How will the amendment affect applications and plans that are already in progress?**

   Applications and person-centered plans with an effective date of July 1, 2026 will be reviewed using:
   - The $500,000 budget cap
   - The exception process

Questions About Budget Cap Exceptions

1. **What are the standards for a budget cap exception?**

   A plan may qualify for an exception if documentation shows the **person needs additional support for health or safety.**

   The budget cap exception standards includes:
   - A Behavior Support Plan and supporting documentation demonstrating the support need for 1:1 or 2:1 staff-to-participant

ratio necessary to support the person with specific behavioral needs.
- A Nursing Care Plan and supporting documentation demonstrating the support need for 1:1 or 2:1 staff-to-participant ratio necessary to support the person with specific health and safety needs.
- The difference between standard and geographical rates that results in the plan exceeding the budget cap.

2. What does "supporting documentation" mean?

Supporting documentation is **additional information about the person's needs** that is submitted with the plan.

This documentation may include assessments completed by qualified professionals, such as:

- Physicians
- Mental health professionals
- Behavioral specialists
- Special educators
- Other licensed health professionals, as appropriate

3. What must the documentation show?

Requests for **enhanced rates, overnight support**, or **1:1 or 2:1 staffing** must clearly explain **why the support is needed**.

A simple statement saying extra staff are needed is **not enough**.

Documentation must explain:

- The **specific needs** that require additional staff
- The **tasks and supports** each staff will provide
- **When and why** extra staff are needed
- The **training or skills** staff must have

Questions About Meaningful Day Service Bucket

1. **What is the Meaningful Day Service Bucket?**

   The Meaningful Day Service Bucket is a **new way to organize meaningful day 15-minute services** in the Person-Centered Plan (PCP) for the provider managed service delivery model.

   Instead of listing each service with separate hours, several meaningful day services will be **grouped together into one shared pool of hours**.

   This makes it easier for people to **choose different activities during the week without needing to update their Person-Centered Plan**.

2. **Is this a new service?**

   No.

   This is **not a new service**. It is simply a new way to **authorize and organize existing meaningful day services** in the Person-Centered Plan.

   Participants will still have access to the same services they use today.

3. **Are provider rates changing?**

   No.

   Rates for meaningful day services are not changing.

   Providers will continue to bill and be paid using the **current established rates for each specific service**.

4. **Why is DDA making this change?**

   The change helps:
   - Give participants **more flexibility in choosing activities**
   - Reduce the need to revise Person-Centered Plans when schedules change

- Improve **budget accuracy** by avoiding over-authorization of services

The goal is to make the system **simpler and more flexible** while still following waiver rules.

Questions About Cost Neutrality

1. **Where can I find information about cost neutrality in the waiver?**

   Cost neutrality information is located in:

   Appendix J – Cost Neutrality Demonstration

2. **What does cost neutrality mean?**

   Cost neutrality is a **federal requirement** for Medicaid Home and Community-Based Services (HCBS) waivers.

   It means the waiver program must **cost the same or less than institutional care** for the same population.

   Institutional care may include:

   - Hospitals
   - Nursing facilities
   - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

3. **How was cost neutrality calculated?**

Cost neutrality calculations use several factors to compare the **cost of waiver services** with the **cost of institutional services**. These factors help show that the waiver program meets the federal cost neutrality requirement.

These include:

Factor C

This is the **estimated number of unduplicative participants during each waiver year.**

Factor D
Average annual cost of **waiver services** for people in the program.

Factor D' (D prime)
Average annual cost of **other Medicaid services** used by waiver participants.

Factor G
Average annual cost of **ICF/IID institutional services** that would be used if the waiver did not exist.

Factor G' (G prime)
Average annual cost of **other institutional services** that might be used without the waiver.

These costs are calculated using:

- Past person-centered plan data
- Medicaid claims data
- Federal reporting requirements
- Cost trend adjustments (such as the Consumer Price Index for Medical Care)

4. What are the Community Pathways cost neutrality factors?

Community Pathways cost neutrality factors of waiver year 3 - 5 are noted below.

Factor D
This is the **estimated average yearly Medicaid cost per person for waiver (HCBS) services**.

- **Waiver Year 3-5:** Calculated using LTSS*Maryland* Fiscal Year 2025 and Fiscal Year 2026 person-centered plan data and actual Medicaid claims from Fiscal Year 2024 and Fiscal Year 2025. Calculated based on:
  - Estimated number of users
  - Average units per user
  - Average cost per unit

Factor D'
This is the **estimated average yearly Medicaid cost per person for other Medicaid services** used by people in the waiver program.

- **Waiver Year 3:** Based on the Fiscal Year 2023 Community Pathways Waiver **CMS 372 Report**, which includes the average yearly cost of non-waiver services.

- **Waiver Years 4–5:** Costs were increased by **3% each year**, based on the change in the **Consumer Price Index (CPI) for Medical Care in the Mid-Atlantic region**, as required by federal guidance.

Factor G
This is the **estimated average yearly Medicaid cost per person for institutional care** in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or another appropriate setting, if the waiver did not exist.

- **Waiver Year 3:** Calculated using actual Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) stay and Medicaid spending data. A **per member per day cost** was calculated and then converted to a yearly cost using the average length of stay in the Community Pathways Waiver (358 days).

- **Waiver Years 4–5:** Costs were increased by **3% annually**, based on the change in the CPI for Medical Care.

Factor G'
This is the **estimated average yearly Medicaid cost per person for other institutional services** not included in Factor G.

- **Waiver Year 3:** Based on actual Medicaid costs for non-Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services that occur during an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) stay. The per member per day cost was annualized using the Community Pathways average length of stay.

- **Waiver Years 4–5:** Costs were increased by **3% annually**, based on the change in the CPI for Medical Care.

5. **Will Appendix J - Cost Neutrality Demonstration be updated?**

   No updates are proposed at this time.

   Cost neutrality calculations are based on **past service use and claims data**.

   Because the budget cap and exception process have **not yet been implemented**, there is no new claims data to update the calculations.

   DDA will continue to monitor cost neutrality and may update it in the future based on **actual claims data**.

Questions About Stakeholder Engagement

1. **How has public input been used in this process?**

   Based on feedback from stakeholders, DDA made the following changes:

   - **Removed the proposed $625,000 exception cap limit**
   - **Removed discharge plan language**

   DDA will continue reviewing public comments and recommendations as part of the amendment process.