Community Pathways Waiver Amendment 2025
Public Comment Summary

The Maryland Department of Health's (MDH) Community Pathways Medicaid home and community-based services waiver provides individual and family supports for persons with developmental disabilities. The public comment period for the Community Pathways Waiver Amendment 2025 proposal was held from June 9 to July 8, 2025. Due to challenges with uploads to the DDA website, Respite Services and Supported Living Services were not posted on June 9, 2025. To address this, the public comment period for Respite Services and Supported Living Services only was extended until July 13, 2025. The DDA received several recommendations for which further engagement with stakeholders is needed. These recommendations were not accepted for this amendment but may inform future amendments. In total, 255 unduplicated individuals, families, providers, advocacy agencies, and public members submitted input. Below is a summary of the input from the public and responses.

Appendix A - Main & Waiver Administration and Operation

Appendix A - Waiver Administration and Operation		
Comment	**Department Response**	**Department Comment**
1. Support consolidation of DDA-operated Medicaid waiver programs. Comments included but not limited to: a. Easier for participants to navigate DDA's services. b. Addresses the confusion and duplication of the existing system while increasing efficiency and effectiveness. c. Processes involved in getting people into the system will be simpler and more efficient. d. Support increased access to services for all eligible individuals in the state of Maryland. e. Will lead to more time for person centered holistic planning. f. Simplify and streamline the various processes within the waiver. g. Common-sense approach to current realities facing both	Accepted	The Department appreciates this feedback. The consolidation will streamline and enhance service delivery by merging the waivers into a single, comprehensive program—the Community Pathways Waiver. By merging the three programs - all participants will have access to the full array of support services, meaningful day services, and residential services, based on assessed needs. This will improve efficiency, ensure equitable access, provide a more person-centered approach to supports, and increase timely access to services.

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self-directed and traditional services. h. We commend DDA on recognizing the need to ensure that individuals with disabilities are not institutionalized and are able to access home and community-based services quickly.		
2. Do not consolidate the DDA-operated Medicaid waiver programs. a. The proposed reforms seem to add more layers of complexity without any real consideration to simplify delivery. b. Keep the Family Supports Waiver.	Not accepted	The DDA-operated Medicaid waiver programs (i.e., Family Supports, Community Supports, and Community Pathways programs) will be consolidated into one single, comprehensive program — the Community Pathways Waiver. Participants enrolled in the Family Supports Waiver will continue to receive services under the Community Pathways Waiver.
3. Waiver Advisory Council and Stakeholder Engagement a. Engage the DDA Waiver Advisory Council and other stakeholder groups early and consistently throughout the process of developing waiver amendments. Ensure people with lived experience have the resources and opportunities to meaningfully take part in both the development and review of waiver amendments and implementation. b. Provide the waiver amendment materials in accessible formats, including documents accessible for people with visual impairments and plain language explanations. c. Restart the waiver amendment process with genuine and transparent stakeholder engagement before submitting the 5-year amendment. d. Work with stakeholders to identify strategies to improve program operation, oversight, and fiscal health. e. Utilize the fully constituted Waiver Advisory Council per HB1244 for advice and recommendations on waiver amendments addressing improvements not absolutely necessary for compliance.	Accepted with amendment	The DDA will continue to engage with people with lived experiences and other stakeholders in the development of amendments. During the first Waiver Advisory Council meeting in October 2024, the DDA created a Waiver Advisory Council Waiver Recommendation Workgroup to do a comprehensive review of the DDA-operated Medicaid Waiver programs and provide recommendations. The DDA will continue to seek input from stakeholders and the Waiver Advisory Council. In addition, a Program Sustainability Taskforce is being created that will include representation of the various stakeholders including people with lived experiences (both in services delivery models and people on the waiting list), families, various types of providers, and advocacy organizations. Materials and documents will be provided in various formats to support accessibility. The Waiver Advisory Council has representation from people and families with lived experience, advocates, providers, and Coordinators of Community Services, from all over the State of

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f. The broader disability community should confirm members of the Waiver Advisory Council. g. Provide meaningful accommodations and accessibility during public engagement.		Maryland. The DDA accepts applications for open positions and is committed to choosing members who represent the diverse people and communities in Maryland. As per recent legislation, the new council shall be appointed by the Secretary of Health.
4. Limit Amendment Focus to: a. Comply with the budget bill. b. Comply with new federal CMS requirements. c. Relate to cost neutrality. d. Proceed only with those waiver amendment elements that are absolutely necessary to ensure compliance with federal and state requirements. e. Focus solely on the necessary adjustments required by the Budget Reconciliation and Financing Act (BRFA), federal requirements, and cost neutrality considerations. f. Proceed only with those waiver amendment elements that are absolutely necessary to ensure compliance with federal and state requirements, including the self-direction act of 2022.	Not Accepted	The amendment updates include requirements to: • Comply with the Fiscal Year 2026 Budget Bill (House Bill 350) and Budget Reconciliation and Financing Act 2025; • Comply with federal requirements; • Update cost neutrality calculations; • Provide participants with new service opportunity; • Provider providers with new service delivery opportunities; • Reflect changes intended to align with current guidance, increase transparency, and improve program consistency; and • Consolidate DDA-operated Medicaid waiver programs which will improve efficiency, and provide equitable access to all essential services, including meaningful day activities, residential supports, and other individualized supports.
5. 30-Day Public Input Period a. Allow for more than 30 days for public comment.	Clarification	Stakeholder engagement is a critical role in shaping waiver programs to better support people with developmental disabilities and their families across Maryland. The DDA will be establishing new stakeholder engagement opportunities, outside the federal formal comment period, to get input on future amendments before proposals are released. For Medicaid waiver programs a formal 30-day public notice and comment period is required.

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6. Termination of Participation standards. Comments included but not limited to: a. Provide a reasonable deadline for when a person is determined to no longer meet eligibility requirements. b. Do not require the Supports Intensity Scale (SIS). c. Change the timeframe from 30 to 90 days for the termination reason when a participant fails to complete any assessments or screenings required by the Department, such as the Health Risk Screening Tool and the Supports Intensity Scale.	a. Clarification b. Accepted c. Not accepted	a. Medicaid issues disenrollment notices and determines dates. b. Failure to complete the Supports Intensity Scale was removed as a reason for termination. c. DDA will seek further stakeholder input related to the timeframe.
7. Waiver Re-enrollment standards. Comments included but not limited to: a. Reinstate individuals once they re-establish eligibility and provide 90 days to re-establish their eligibility without service disruption. b. Add that the Eligibility Determination Division (EDD) must assure timely processing of waiver and Medicaid redetermination applications, including providing timely and helpful assistance to participants to support their re-enrollment efforts, within 90 days. c. Add individuals may be re-enrolled immediately upon resolving the issues that lead to their disenrollment, even if the disenrollment has crossed an immediately preceding waiver year. d. Remove the requirement in subsection 1.b. under “Waiver Re-Enrollment” that a waiver slot and funding must be available for re-enrollment. e. Establish a reinstatement process for individuals who lose waiver eligibility due to administrative errors or delays. As redetermination timelines evolve under new federal regulations, safeguards should be in place to ensure continued access for those actively engaged in appeals or	Not accepted	Individuals are reinstated based on Medicaid rules. Medicaid waiver coverage will only reopen if the individual is found eligible after review. If the individual is not found eligible, they will need to reapply for coverage by submitting a new waiver application. Individuals have 4-months (or 120 days) to be reinstated from the due date to submit a signed renewals/redetermination packet. Individuals may re-enroll in the Medicaid waiver program if: a. The individual meets eligibility requirements; and b. The Medicaid waiver program has a slot and funding available to support re-enrollment. 2. An individual may be re-enrolled in the Medicaid waiver program as provided in either: a. During the same waiver year; b. Within 90 days of termination; or c. Subsequent waiver years based on reserved categories and placement on the waiting list.

resolution processes.		The DDA will continue to work with Medicaid to support processes and improvements related to enrollment and redeterminations.
8. Program Integrity, Oversight, Assurances, and Program Design a. Clarify standards for "program integrity" and "health and safety", including due process protections and definitions. b. Incorporate protections for systemic remediation including independent reviews and public dashboards. c. Strike or revise all involuntary SDS termination provisions, replacing them with individualized, appealable reviews. d. Restore full participant autonomy in selecting Support Brokers and negotiating with Financial Management and Counseling Services. e. Ensure medical necessity and person-centered planning remain central to service eligibility and scope. f. Add participant/family oversight mechanisms, including feedback loops and external complaint systems.	a. & b. Clarification c. Not accepted d. Clarification e. Clarification f. Clarification and not accepted f. Clarification	a. & b. In order for the federal government to approve a new Medicaid waiver or the renewal of an approved waiver, a state must make certain assurances concerning the operation of the waiver. The federal waiver template is designed to address how the state's Medicaid waiver program is designed to meet these assurances Medicaid programs include multiple program integrity, health and welfare, and due process requirements. Program integrity refers to the measures taken to ensure that government programs are administered efficiently, effectively, and ethically, with minimal waste, fraud, and abuse. As one of the federal assurances, states are responsible for proper payments in Medicaid programs. Examples of the DDA-operated Medicaid waiver program program design include but are not limited to: quality and claims reviews by a federally certified Quality Improvement Organization, program safeguard standards, and service audits for both service delivery models. The Quality Improvement Organization conducts independent reviews and shares recommendations related to systemic remediation and enhancements including public dashboards. To be approved by the federal government, states must also demonstrate it has designed and implemented an effective system for assuring waiver participant health and welfare including: ● The state must demonstrate on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

		• The state must demonstrate that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible. • State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed. • The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver. Reference: Appendix G Due process protections are outlined in Appendix F: Participant Rights which includes "Procedures for Offering Opportunity to Request a Fair Hearing." c. In the event the DDA terminates the participant's enrollment in the Self-Directed Service Delivery Model in accordance, the DDA shall notify in writing the participant, legal guardian, or their designated representative (as applicable), their Coordinator of Community Services, Support Broker, and the Financial Management and Counseling Services provider. This notice shall include: The date and basis of the DDA's determination; and The participant's right to a Medicaid Fair Hearing as described in Appendix F. d. Participants have autonomy to select among certified Support Brokers and approved Financial Management and Counseling Services providers. e. The DDA-operated Medicaid waiver programs provide habilitative services based on assessed needs. f. Oversight and safeguards are included within the waiver application and can be enhanced with further stakeholder

		engagement. The creation of a Medicaid waiver specific grievance/complaint System can also be considered with further stakeholder engagement
9. Interagency Agreements a. Publish the DDA–OLTSS Interagency Agreement, as required by 42 CFR § 431.10	Not accepted	42 Code of Federal Regulations § 431.10 does not require publication.
10. Contract Terms a. Define enforceable contract terms, including performance penalties and transparency standards. b. Clarify the Medicaid agency's direct supervisory role in each contracted task.	Not accepted	Medicaid waiver applications include information related to the use of contracted entities who perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable). The requirement for the application is to specify the types of contracted entities and briefly describe the functions that they perform. Enforceable contract terms, including performance penalties and transparency standards are reflected within the signed contract with the entity.

Appendix B - Participant Access and Eligibility

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1. Institution and Institutionalization Terminology a. Do not use the words, "institution" or "institutionalization." Instead please change the language	Clarification	The federal Medicaid waiver application and guidance uses the terms "institution" and "institutional" in various sections. These words are part of the waiver application. In the context of the waiver application, a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities are

to "Residential Center" (or similar).		the comparable institutional level of care for which the state makes Medicaid payment under the state plan.
2. Funding for Adults a. Ensure the expansion of services to children and youth does not reduce access or funding for adults. b. Include safeguards in the waiver to maintain equity across age groups.	Clarification	Individuals, regardless of age, are prioritized for entrance to the waiver based on: (1) reserved capacity categories;and (2) the Waiting List priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12. Reserved capacity categories are established for discrete groups of individuals including: (1) Crisis Resolution; (2) Waiting List Equity Fund; (3) Family Supports Waiver Participants with Increased Needs; (4) Military Families; (5) Maryland State Department of Education (MSDE) Residential Age Out; (6) Department of Human Services (DHS) Foster Kids Age Out; (7) Families with Multiple Children on Waiting List; (8) Previous Waiver Participants with New Service Need; (9) End the Wait Act 2022; (10) Money Follows the Person; (11) Emergency; (12) State Funded Conversions; (13) Transitioning Youth; (14) Psychiatric Hospital Discharge; (15) Court Involvement; (16) Community Support Participants with Increased Needs; and (17) Deinstitutionalization. The Medicaid waiver programs include various safeguards that are federally required.
3. Reserved Slots a. State Funded Slots - i. Restore slots under the state funded conversions reserved slots category. ii. Add some reserved capacity for State-Funded participants in Year 4 in recognition that despite the state's focus on smarter more effective operations, delays happen. b. End the Wait Act 2022 Slots -	Not accepted and clarifications	Individuals, regardless of age, are prioritized for entrance to the waiver based on: (1) reserved capacity categories;and (2) the Waiting List priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12. Reserved capacity categories are established for discrete groups of individuals including: (1) Crisis Resolution; (2) Waiting List Equity Fund; (3) Family Supports Waiver Participants with Increased Needs; (4) Military Families; (5) Maryland State Department of Education (MSDE) Residential Age Out; (6) Department of Human Services (DHS) Foster Kids Age Out; (7) Families with Multiple Children on

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i. Restore the slots with the understanding that funding may not be available. immediately but is intended to be provided in future budget cycles. ii. Retain the 75 End the Wait Act reserve category slots. c. Recommend reserving 10 waiver slots annually for former participants who are eligible for re-enrollment. d. Maintain the current 30 reserved slots for DHS Foster Kids Age Out under "Reserved Waiver Capacity" . e. Add reserve slots for people who lose eligibility and are unable to return to the waiver through one of the other categories of reserve slots when they are redetermined to be eligible (without returning to the waitlist). f. Maintain 5 slots reserved for previous waiver participants with new service needs. g. Ensure transparent criteria and waitlist equity in reserved capacity prioritization.		Waiting List; (8) Previous Waiver Participants with New Service Need; (9) End the Wait Act 2022; (10) Money Follows the Person; (11) Emergency; (12) State Funded Conversions; (13) Transitioning Youth; (14) Psychiatric Hospital Discharge; (15) Court Involvement; (16) Community Support Participants with Increased Needs; and (17) Deinstitutionalization. DDA has a focused effort for enrollment of DDA State Funded participants as noted in the budget bill. State Funded slots were increased to 300 to support this effort. Individuals disenrolled from services also have the right to appeal the disenrollment decision. Slots were adjusted based on historic data and funding. Slots can be requested if funding is allocated. Further discussions related to slots can be considered by the Program Sustainability Taskforce.
4. Require Coordinators of Community Services to: a. Provide unbiased, balanced information to individuals about the opportunities, structures, services available, benefits, and responsibilities associated with both Provider Managed and Self-Directed Services Models with opportunities to visit or interview with people associated with both models to get a feel for what each service model is about, and b. Document attestation that the individual is making their decision of service model, free from conflict, coercion, or judgement from their circle of support to the best of the Coordinators of Community Services' knowledge. The initial information provided during planning stages about the different service models should be developed with	a. Clarification b. Accepted with amendment	a. The Coordinator of Community Services provides information to each participant and their legally authorized representative, (as applicable), and other identified planning team members regarding available Medicaid waiver program services, service delivery models (i.e., Self-Directed Services and Provider-Managed Delivery Model), qualified providers, and availability of service providers. The Coordinator of Community Services assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, outcomes, and preferences. The choice of service delivery model is documented on the Freedom of Choice form and the Person-Centered Plan. b. The DDA will seek input from stakeholders on the information provided by Coordinator of Community Services about the different service models with input from people with lived experience in both models and other stakeholders.

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input from people with lived experience in both models and other stakeholders.		
5. Consolidation - Participant Notification and Transition Plan a. We commend DDA for proactively notifying participants about the transition b. DDA's efforts to automatically enroll all waiver participants in the new Community Pathways Waiver, ensuring continuity of coverage and protecting recipients from the risk of institutionalization, abuse, or neglect is greatly appreciated c. DDA should outline clear precautionary measures to address any lapses in coverage after the waiver consolidation. DDA can designate a representative within each regional office as a dedicated point of contact for participants facing issues related to their transition to the Community Pathways Waiver.	a. & b. Accepted c. Clarification	a. & b. The Department appreciates this feedback. c. The Department will actively monitor the system data patches used to identify any concerns and remediate.
6. Waiver Enrollment Additional Criteria a. Clarify whether participants who wish to enroll in the traditional service model are required to complete the mandatory self-direction training requirement, as outlined in Appendix B under "Additional Criteria."	Clarification	Individuals interested in the Provider-Managed service delivery model are not required to complete the self-direction training requirement. Information related to the self-directed services training requirement will be removed from this section as the training requirements are outlined in Appendix E.
7. Access to Services by Limited English Proficient Persons a. Restore, on page 35, the access to interpreter resources for people who contact DDA for information, requests for assistance, or complaints.	Clarification	The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents.

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		The State also provides translation services at Medicaid Fair Hearings, if necessary. If an Limited English Proficiency appellant attends a hearing without first requesting services of an interpreter, the Administrative Law Judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured. The DDA utilizes the State resources and does not have additional interpreter resources.
8. Backdating Medicaid Eligibility a. Add provisions for backdating Medicaid waiver eligibility and service authorization when disenrollment is found to have been caused by Department or system error. Backdating should restore eligibility and services to the date when coverage was incorrectly terminated, ensuring no lapse in funding or service delivery. This is critical to prevent service interruptions and provider payment gaps that negatively impact participants' health and safety	Not Accepted	Medicaid determinations are completed by the Office of Eligibility Services based on Medicaid requirements. If an error or system issues occurs, corrections are made by the Eligibility Determination Division.
9. Safeguard - Administrative or System Errors a. We recommend safeguards to prevent loss of services due to administrative or system errors, including automatic reinstatement, extended re-enrollment timelines, a clear appeals process, and written notices with resolution steps. Coordinators of Community Services should be promptly informed and required to assist participants to avoid service gaps.	Not accepted and clarification	The Department is continuously looking at ways to streamline systems, prevent system errors, and ensure people have access to the services they need within Medicaid rules. Individuals are reinstated when errors are identified. As noted in Appendix F, the Maryland Department of Health informs the individual and their family or their legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA or the Maryland Department of Health.

		The Maryland Department of Health has a new dedicated website - "Request a Fair Hearing. File an Appeal" that includes information related to: ● Your Fair Hearing Rights; ● Notice of Hearing Date and Location; ● Before the Hearing; ● During the Hearing; ● Hearing Decision; ● Frequently Asked Questions; ● The option to submit a fair hearing request online for anyone applying for or enrolled in Medicaid who thinks a decision to deny, suspend, end, or reduce their Medicaid eligibility or services is wrong has the right to ask for a fair hearing about that decision; and ● Ability to submit a Request for Fair Hearing via mobile request form. The website can be viewed at https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx Coordinators of Community Services and DDA providers are alerted via the LTSS*Maryland* system when an individual loses Medicaid waiver eligibility so that remediation actions can be taken as applicable.
10. Autism Waiver Participants Enrollments a. Add Autism Waiver participants to the Community Pathways Waiver as soon as their secondary schooling ends.	Clarification	Individuals must complete the DDA-operated Medicaid waiver program application process and be determined to meet eligibility prior to enrollment. DDA has slots allotted for transitioning youth (TY) every year. Transitioning youth are individuals who are aging out of school and into adult services. These slots are available to make sure that they can access services timely and avoid gaps in services. It is important to note that not everyone in the Autism Waiver will be

		eligible for services in the Community Pathways Waiver, as there are different eligibility requirements.
11. Automated Eligibility - Social Security Income Benefits a. DDA should grant automatic waiver eligibility to applicants already approved for federal Supplementary Security Income benefits. This would ease the burden on the overstretched Eligibility Determination Division, reduce delays, and minimize harm to participants	Not accepted	Individuals must meet technical, medical, and financial eligibility to be enrolled in a Medicaid waiver program. Consideration of Supplementary Security Income benefits only does not mean an individual meets all of the eligibility requirements. The Office of Eligibility Services - Eligibility Determination Division determines Medicaid waiver financial eligibility determinations. The Eligibility Determination Division reviews applicants current Medicaid eligibility to include Supplementary Security Income benefits during their assessment.
12. Add due process protections for disenrollment decisions to include: a. Written notice; b. Right to appeal; and c. Right to representation.	Clarification	As noted in Appendix F, the Maryland Department of Health informs the individual and their family or their legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA or the Maryland Department of Health. The Medicaid Fair Hearing Rights Notices includes information about the right to represent yourself, have legal counsel, or use an Authorized Representative. The Maryland Department of Health has a new dedicated website - “Request a Fair Hearing. File an Appeal” that includes information related to: ● Your Fair Hearing Rights; ● Notice of Hearing Date and Location; ● Before the Hearing; ● During the Hearing; ● Hearing Decision; ● Frequently Asked Questions;

		• The option to submit a fair hearing request online for anyone applying for or enrolled in Medicaid who thinks a decision to deny, suspend, end, or reduce their Medicaid eligibility or services is wrong has the right to ask for a fair hearing about that decision; and • Ability to submit a Request for Fair Hearing via mobile request form. The website can be viewed at https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx
13. Non-Compliance a. Define "non-compliance" and "health/safety" risks with objective criteria	Clarification	For Appendix B performance measures, non-compliance is when: • An level of care if not completed • An level of care is not completed as per Appendix B- 6 Level of Care criteria and procedure standards Objective standards are outlined in the Quality Improvement Organizations quality review standard operating procedures. Health risks are identified with the Health Risk Screening Tool and person-centered planning. The Health Risk Screening Tool assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. Reference: Appendix D

14. Self-Directed Services to Provider-Managed Model Transitions a. Add participant-centered planning review before any SDS-to-provider model transitions.	Clarification	A Person-Centered Plan must be created, reviewed, and approved as part of the transition.
15. Self-Directed Services Disenrollment Reasonable Accommodations a. Incorporate reasonable accommodation provisions in Self-Directed Services disenrollment policy.	Clarification	The Office of Administrative Hearings (OAH) sends notices to individuals on how to request accommodations, if necessary.

Appendix C- Participant Services, General

Appendix C- Participant Services		
Comment	**Department Response**	**Department Comment**
1. Dedicated Hours Authorization Comments included but not limited to: a. Changes in the waiver amendment are especially positive in supporting quality supports by community providers, resulting in improved outcomes for individuals. b. Agreement of use of requiring a nursing care plan or behavior plan for the allocation of dedicated hours, as this has played a critical role in ensuring that services are driven by assessed need and aligned with the goals outlined in the Person-Centered Plan. c. Utilize independent scoring mechanisms such as the	Accept with amendment	The Department appreciates this feedback. The DDA will explore with stakeholders other independent scoring mechanisms and validated tools to authorize dedicated hours. On August 15, 2022, Maryland became a Technology First State through a governor's proclamation. This means Maryland is committed to empowering all Marylanders with disabilities to have access to technology that will help them live, work and play in their communities. Technology First is defined as: • A “framework for systems change where technology is considered first in the discussion of support options

Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), or other validated tools to determine eligibility thresholds for approving dedicated hours for new participants. d. Strengthen case management oversight to ensure that dedicated hours are requested only after Assistive Technology and Remote Supports have been appropriately explored. e. Clarify the language regarding dedicated in-home hours for retired individuals to specify that staffing may be either shared or 1:1, based on the needs outlined in the Person-Centered Plan. f. Clarify the language that allows for people who are retired to have dedicated hours in the home to state that the staff can be shared or 1:1, depending on the needs identified in the person's plan.		available to individuals and families through person-centered approaches to promote meaningful participation, social inclusion, self-determination and quality of life." (Tanis, E.S. (2020) Advancing Technology Solutions for People with IDD in Colorado. Alliance Board Meeting. Denver, CO.) The DDA will continue to share information with all stakeholders about the importance of discussing and exploring technology options for participants. If the participant needs dedicated support hours due to medical or behavioral support needs, daytime support needs, or increased community integration needs, then a request for dedicated staff hours may be submitted as per guidance and policy.
2. Dedicated 1:1 And 2:1 Support, Enhanced Supports, and Overnight Services Requirement For Behavioral Support Plan Or Nursing Care Plan Standards ● Remove requirements for Behavioral Support Plan or Nursing Care Plan. ● Review and study new requirements to consider implications of changes. ● Expand the criteria for 1:1 support to include access for individuals who require personal assistance for the use of advanced communication technology. ● Return authority to the person-centered planning team to justify the person has an assessed need for increased support in the form of 1:1 or 2:1 which may be supported by a Behavioral Support Plan or Nursing Care Plan or other	Not Accepted	The following criteria will be used to authorize 1:1 and 2:1 staff-to-participation ratio, enhanced supports, and overnight services: a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio, enhanced supports, and overnight services to support the person with specific behavioral needs; or b. The participant has an approved Nursing Care Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio, enhanced supports, and overnight services necessary to support the person with specific health and safety needs. c. The DDA may authorize dedicated support for participants new to services and participants in services who have a specific, documented behavioral need for up to 6 months while a Behavior Support Plan gets authorized and developed.

documentation reviewed by the team and DDA prior to approval. ● Allow Rare and Expensive Case Management (REM) nursing plans to be used to satisfy the criteria for 2:1 or enhanced supports.		
3. "Unless Otherwise Authorized by the DDA" Comments include but not limited to: a. Reinstate, "unless otherwise authorized" in regard to enhanced and dedicated hours being required to have justification with a nursing care plan or a behavior plan. b. Recognize and support the needs for enhanced supports for Deafblind+ Individuals in the proposed Waiver Amendment. c. Add the language, "extensive assessed medical needs" as a means to get enhanced or dedicated hours. d. There is no mention in this amendment of how the state will accommodate individuals who do not fit easily into existing categories like Rare and Expensive Case Management (REM) or the Autism Waiver. Removing case-by-case discretion and refusing to provide clear, objective, medically sound criteria for evaluating needs invites subjectivity and systemic bias. Worse, it places decisions in the hands of reviewers who are not clinically or medically trained to understand the rare or complex conditions they're assessing—an issue that borders on operating outside the scope of professional licensure. e. DDA should retain flexibility for granting enhanced supports in extraordinary cases (even if they are not strictly medical/behavioral), rather than a one-size-fits-all cutoff. Failing to do so may compromise participant health and safety – the very outcomes the waiver is meant to	Not Accepted	For transparency and consistency, the standards for authorization of dedicated hours are reflected within the amendment. Based on the participant's assessed needs, the DDA may authorize dedicated hours for 1:1 and 2:1 staff-to-participant supports or enhanced supports when: ● The participant has an approved Behavior Support Plan documenting the need for 1:1 and 2:1 staff-to-participant supports or enhanced supports to support the person with specific behavioral needs; ● The participant has an approved Nursing Care Plan documenting the need for 1:1 and 2:1 staff-to-participant supports or enhanced supports to support the person with specific health and safety needs. The DDA may authorize dedicated support for participants new to services and participants in services who have a specific, documented behavioral need for up to 6 months while a Behavior Support Plan gets authorized and developed. The DDA may authorize Nursing Support Services in an Emergency Revised Plan for participants in services who have a specific, documented health and safety need to support the development Nursing Care Plan and subsequent request for dedicated support. The DDA-operated Medicaid waiver programs provide habilitative community-based services and supports.

protect.		Individuals enrolled in the Rare and Expensive Case Management (REM) can receive skills services based on assessed needs. Individuals can only be enrolled in one Medicaid waiver program, therefore individuals in the Autism Waiver would have their needs and services provided under the Autism Medicaid waiver program. The DDA will explore with stakeholders other standards and strategies such as independent scoring mechanisms and validated tools to authorize services.
4. Residential Services for Minors a. Reinstate the language allowing DDA the ability to authorize services for someone under the age of 18.	Not accepted	The DDA is one of many resources, services and supports available to assist individuals and families as they build their lives toward their vision of a "Good Life". The DDA works collaboratively with other government agencies to offer appropriate support services and resources to children who are in need of residential services. The DDA's residential services are designed and licensed to support adults. As per Maryland Statute and regulations, the DDA approves and the Office of Health Care Quality licenses residential group homes that provide services to individuals with developmental disabilities. The DDA funds licensed group homes to support adults. The Department of Human Services (DHS) funds licensed group homes to support children. The DDA works with the Department of Human Services, Maryland State Department of Education (MSDE), and school systems to locate appropriate residential services. This includes connecting them with DDA licensed providers for which the Department of Human Services or the school system funds and oversees. Youth, ages 18-20 who meet DDA's eligibility, may access residential services and move into a DDA licensed adult home. For youth who receive funding from the Department of Human Services, the home must also be approved by the Department of

		Human Services, to allow the Department of Human Services funding to continue until the age of 21. This supports a better transition for many youth who have had multiple placement changes in their life. Local Care Teams (LCTs) are multidisciplinary teams composed of representatives from the local school system; local Department of Social Services; local Department of Juvenile Services; local management board; local behavioral health administration; and a representative from the DDA regional office. There may also be other community partners that are brought to the table. The Local Care Teams are held throughout the various jurisdictions in Maryland and convene at the request of the family or professionals on behalf of the family. The Local Care Team offers resources and assists the family in accessing services and supports needed.
5. Self-Direction Principles a. Strengthen the principles of self-direction by reducing unnecessary pre-approvals and regulatory barriers that limit participant and family autonomy. a. Shift the focus of oversight to outcomes such as participant safety, health, and satisfaction rather than micromanaging care arrangements. b. Oversight mechanisms should be supportive and person-centered, not punitive, allowing participants and their chosen support networks to make meaningful decisions about their care.	Clarification	Medicaid waiver programs include required federal assurance and safeguards related to health and welfare and financial accountability and integrity within Medicaid rules.
6. Meaningful Day Service Authorization a. Redesign the authorization procedures for Meaningful Day Services to increase flexibility and participant choice. Specifically reconsider the rigid division between Day	Accepted with amendment	The Department appreciates this feedback, and will have further engagement with stakeholders.

Community Pathways Waiver Amendment 2025

Public Comment Summary

Habilitation services and Community Development Services. a. Explore a more integrated or person-centered authorization model that allows participants to more easily tailor services to their individual needs and preferences.		
7. In-Home Family Caregivers To Claim Approved Service Hours a. Establish a flexible policy that allows in-home family caregivers- particularly those who are single, divorced, or widowed to claim approved service hours when staff are unavailable due to no-shows or call-outs. b. Develop a system that includes a pre-approved bank of overtime (OT) hours for live-in family caregivers, allowing: i. Straight-time pay beyond 40 hours per week in compliance with Maryland law. ii. Advance approval of a set number of Overtime hours in the Person-Centered Plan/Budget year to be used when staff coverage fails, with appropriate documentation. iii. Resubmission of requests if the pre-approved hours are exhausted, provided proper documentation supports continued need. iv. A review process if usage exceeds reasonable thresholds, offering problem-solving support or connection to additional family support resources.	Not accepted	Participants have the choice to use employees and DDA-licensed/certified providers to meet their services needs and service delivery model. Participants are also required to have and access their back-up plan and emergency plans when staff are not available. Qualified and approved in-home caregivers can provide paid supports based on the authorized Person-Centered Plan. Participant's self-directing services are responsible for monitoring the usage of authorized services and budget. They are supported by their team which includes the Coordinator of Community Services and Financial Management and Counseling Services provider in addition to Support Broker and other team members as applicable. The DDA has a dedicated webpage for Supporting Families in Maryland that includes various family support resources. See - https://health.maryland.gov/dda/Pages/Family%20Members.aspx
8. Meaningful Day Services Training Policy Staff Qualification Requirements a. Request that the DDA not make changes to the training standards required for Provider Managed Model employees at this time.	Accepted with amendment	Staff working must satisfactorily complete required orientation and training designated by DDA. The DDA removed the inclusion of the Meaningful Day Services training policy staff qualification requirements and will further engage with the stakeholders.

b. Provide opportunities for further discussion, consideration of impacts to the workforce, and an examination of the brick components to ensure the training portion of the service funding rate in the brick is sufficient. c. A 3-month period of time is needed to adequately train DSPs, during which they can safely provide direct support while not working alone. d. Remove the new requirement that staff have certain training (e.g., MANDT) before being able to provide direct support. e. Amend waiver to allow people to provide direct support during an allowable training period, as long as they are working with other staff who have completed the training. f. A 3-month period of time is needed to adequately train DSPs, during which they can safely provide direct support while not working alone. g. Align the Mandt training requirement with the 90-day timeframe in the training matrix, rather than requiring completion before staff begin working.		
9. DDA Training Matrix a. Update the training matrix to clarify requirements across services and ensure consistency with the waiver and DDA policy.	Accepted	DDA will update the training matrix to align with the waiver amendment and policy.
10. High School Diploma or GED Requirement a. Minimum education requirement for Direct Support Staff should be a High School Diploma Diploma, GED, or equivalent (equivalent as documented through official attestation). b. Do not remove the High School Diploma/GED requirement for direct support staff hired to provide services to	Not accepted	This elimination of High School Diploma/GED for expanding the pool of qualified providers and supports staff training taking priority over degree.

participants in Community Living Group Home settings and for Community Living Group Home Enhanced Supports. c. Keep the High School equivalent for staff so as not to undermine the professional need for this type of worker. d. The DDA should prioritize the quality of care and communication needed to support participants with complex needs in the hiring of staff. e. Maintaining the minimum educational qualification standard of a High School Diploma/GED will ensure staff possess the necessary literacy and communications skills needed to understand the participant's care needs, document services accurately and interact effectively with participants, their families and healthcare professionals. f. To help address the lack of direct support professionals, working to give them a career path, benefits, etc. would lead to this being a professional career. That would be more likely to attract people to this field long term. By removing the requirement of a High School Diploma, the positions don't seem to be positions that lead to a career.		
11. Virtual Supports a. Do not remove telehealth services from many services in the waiver. The complete elimination of telehealth prevents individuals with disabilities, particularly those who are immunocompromised or face mobility challenges, from accessing the full range of services under the waiver b. Removing the following requirements for virtual supports and replace with a requirement for the team to consider and identify supports, if any, that are needed by the individual to safely and successfully participate in virtual supports: • Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are	Clarification	The Center for Medicare and Medicaid Services added new data elements associated with telehealth/remote supports to the federal waiver application and technical guide. This includes a new check box associated with each service and a designated section within Appendix C -1 d. Remote/Telehealth Delivery of Waiver Services. During the public health emergency, the DDA's Emergency Appendix K authorized the use of services to be provided virtually/remotely in lieu of face-to-face meetings. Several programs developed new virtual support business models that supported participants while also keeping them safe in their home. The DDA amended the Medicaid waiver programs in 2020 to include virtual supports as an electronic method of service delivery. Services that may be provided virtually include:

present while services are being provided virtually, as indicated, in case the participant experiences an emergency; and ● How a person will get emergency interventions if the participant experiences an emergency, including contacting 911 if necessary c. Recommend incorporating greater flexibility in the language regarding the use of Virtual Supports. Specifically, individuals should be permitted to utilize Virtual Supports without a caregiver physically present, when this arrangement is supported by their Person-Centered Plan. This recognizes the diverse needs of individuals, particularly those who face transportation barriers, and supports appropriate use of technology in service delivery. d. Clarify that the use of virtual supports is a choice made through the person-centered planning process, and that risk mitigation strategies (including back-up plans that do not rely solely on unpaid caregivers) should be developed collaboratively		Employment Services, Community Development Services, Day Habilitation, and Personal Support services. The amendment includes documenting the requirements that were previously noted in the Medicaid waiver document. Reference: Memo #3 - DDA Amendment #3 - Virtual Supports - February 16, 2021 Individuals may receive Medicaid State Plan services (doctor visits, etc.) via telehealth. For more information please see the Department's designated Telehealth website. The DDA will further engage with stakeholders on this service delivery option and standards.
12. Employee Designation As Medicaid Provider a. Require employees to attest, upon hire, their understanding that as an Employee providing Medicaid-funded services, their work must follow all Medicaid and Waiver Requirements. Even as employees are not Medicaid Providers themselves, they must: i. Deliver services as written in the participant's approved Person-Centered Plan, and document provision of services in accordance with DDA requirements. ii. Follow Medicaid program rules, including completing required training and documentation. iii. Protect health, safety, and rights or participants, and report any incidents.	Accepted with amendment	The DDA will engage with stakeholders on these recommendations. Anyone paid to provide a Medicaid waiver service, including participant's employees, is considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

iv. Avoid fraud, waste, or abuse — such as claiming time for pay they didn't actually work, which constitutes theft of the government, and Medicaid Fraud. b. Determine how to oversee and monitor compliance and address validated waste, fraud, and abuse associated with employees working in both service models. c. Clarify what it means that employees are considered Medicaid vendors. d. Limit Medicaid Provider designation to agencies or credentialed professionals.		
13. Acute Care a. Changes in the waiver amendment are especially positive in supporting quality supports by community providers, resulting in improved outcomes for individuals b. Strongly support the inclusion of "acute care hospital setting" for some waiver services	Accepted	The Department appreciates this feedback.

Appendix C 1 and 2-5

Appendix C 1 & 2-5		
Comment	**Department Comment**	**Department Response**
1. Assurance of Qualified Providers Quality Improvement Strategy a. Provide additional guidance on the provider self-assessment tool. This should include:	Clarification	To improve compliance with the Qualified Provider performance measures a quality improvement strategy is noted with the waiver.

• Clear descriptions of the metrics to be used • Detailed requirements for completing the self-assessments • Designated points of submission and • A description of the oversight process		The specific performance measure related to DDA Licensed Providers continuing to meet required licensure and standards. The provider self-assessment tool is to assess current status, updates, challenges, and concerns related to the provider's renewal application, Program Service Plan(s), Quality Assurance Plan, Community Settings, incident reporting, and provider performance. Technical assistance will be provided, and remediation strategies and due dates developed as applicable. The amendment added the following additional details related to the provider self-assessment tool. • DDA's Provider Services staff will notify providers via email and include a provider self-assessment tool at least 120-days prior to the DDA license approval expiration date to submit the renewal application. Providers must complete the tool by 90-days prior to DDA license approval expiration date. Technical assistance will be available throughout the process. The DDA will share additional information regarding the tool and process with stakeholder input.
2. Supported Decision Making Agreement To Meet Federal Requirement For Substitute Judgement. Comments included but not limited to: a. Explore alternate procedures which allow participants who do not have the capacity to sign Supported Decision-Making agreements to receive services from legally responsible individuals when other requirements are met without any conflicts of interest. b. Offer a few viable options for the participant's consideration. These options may include but should not	Accepted with Amendment	A Substitute Judgement document will be required for participants who have legally responsible individuals, legal guardians, or relatives providing services that have decision making authority over the selection of waiver service providers. The DDA will work with the Waiver Advisory Council for input on the documentation requirements. The requirement for a Supported Decision Making Agreement to meet federal requirements for Substitute Judgement will be removed from the amendment proposal.

be limited to a Supported Decision Making agreement, a formal agreement with an unpaid person unrelated to the legally responsible staff person (similar to what other states allow), a Limited Power of Attorney, or other similarly recognized toolEliminate mandate for Support Decision Making Agreement. c. The Participant Agreement can be revitalized and edited to meet the needs of identifying partners that can assist. d. Add a line to the Participant Agreement form to avoid conflict of interests. Include the representative who will have substituted judgment for the participant. e. Create a way that families can opt out of Supported Decision Making agreements. f. Ensure that any language in the waiver regarding Supported Decision Making clearly states that it is voluntary and not a condition of access to a service or program g. Remove or reject any provision that suggests or implies a requirement to enter into an Supported Decision Making agreement in order to hire family as paid staff or fulfill employer duties h. Reaffirm that person-centered planning must reflect the will and preference of the individual, not bureaucratic compliance tools i. Require that when a participant utilizes legally responsible individuals, legal guardians, and/or relatives as providers, and the participant is unable to independently make service delivery decisions, an alternative substitute decision maker, as outlined under MD Code, Health - General, § 5-605(a)(2), who is not a provider will be utilized. If such an alternative substitute decision maker is not available or willing to assist, then the person-centered plan must document that the legally responsible individuals, legal guardians, and/or relatives that are also provider(s) affirm that the participant's preferences were considered in making the services delivery decision(s)		

j. Create a stakeholder workgroup to establish best practices related to hiring family members as staff and supported decision making agreements. k. Reconsider the substantive prohibition that relatives providing services "can not make decisions regarding service delivery (e.g., wage rates, number of hours, etc.). l. Prevent conflicts of interest and do not unnecessarily complicate the ability of many participants' parents to serve as staff.		
3. Legal Guardians, Legally Responsible Persons, and Relatives as Paid Staff a. Legal guardians should not be able to be staff and should serve as the designated representative. b. Consider family as staff being added to the 40-hours maximum across all participants served. c. Require training on the use of the Family as Staff form and offer technical assistance to all team members, including people with disabilities, families, support brokers and other team members. d. Cap on 40-hours per week for legally responsible individuals. e. Put a cap on family as staff hours to 40 total per household, not per person. Allowing every member of the household to "work" 40 hours each per week does not allow for any natural support time. This would reduce some of the fraud that is happening as parents are expecting to get paid for "being a parent" and not teaching their child/adult child to become independent." f. Preserve family as staff as a vital part of the direct care workforce prospectively and remove barriers that cause confusion or may be out of compliance with state or federal laws. g. Eliminate the 40-hour cap on service hours for legally	Not accepted	Families can provide paid services under the Medicaid waiver program as noted in Appendix C. The relatives, legal guardians, and legally responsible person can provide no more than 40-hours per week of the service. The State must ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual. The DDA will further engage with stakeholders on standards and additional safeguards associated with legal guardians, legally responsible persons, and relatives as paid staff. The DDA will enhance training associated with the use of legal guardians, legally responsible persons, and relatives as paid staff.

responsible persons. h. Allow legally responsible persons and legal guardians who provide services to participate in service delivery decisions including wages, rates, and hours to support participant choice and promote flexibility in care arrangements. i. Allow legally responsible persons to provide services to the participant. j. Offer an optional monthly stipend or salary model for full time family caregivers. k. Include criteria and process for seeking justified exceptions above 40-hours/week.		
4. Relative Definition a. Maintain the current definition of 'relative' for participants in Self-Directed Services. b. Recommendation to consider adding children to the definition of relatives.	Not accepted and clarification	A relative is defined as a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew. The definition of relative includes children.
5. Family Monthly Stipend a. Offer an optional monthly stipend to family caregivers who provide full time care.	Not accepted	The DDA-operated Medicaid waiver program direct services are based on a fee-for-services.
6. Legally Responsible Persons Request Form a. Remove the requirement for legally responsible persons to submit a request form to the Developmental Disabilities Administration for approval before using a legally responsible person to provide services. b. Streamline this process or eliminate the extra approval step, so that participants retain the autonomy to choose their caregivers – including family – as long as basic	Not accepted	A request form for the use of a legally responsible person, legal guardian, and/or relative will be required. The form will support the State's ability to track, trend, report, and ensure an independent Support Broker as required by the Self-Directed Services Act of 2022 under the self-directed service delivery model (as applicable). The DDA will automate and streamline the process.

qualifications are met.		
7. Participant Agreement a. Use the Participant Agreement as an additional safeguard that outlines the role of each team member. b. Recommend that Coordinators of Community Services be required to review the Participant Agreement in full with the entire team.	Accepted with amendment	The DDA will further engage with stakeholders on additional safeguards that outline the role of each team member.
8. Revise the language regarding the review of services provided by legal guardians and relatives to align with existing utilization review practices. a. Specifically, claims should be reviewed to ensure they are supported by appropriate documentation, delivered by qualified providers, consistent with the approved service plan, and in the best interest of the participant.	Clarification	The Quality Improvement Organization quality review of services include paid services provided by legal guardians and relatives.
9. Legal Guardian a. Recommendation: Do not require participants to have a legal guardian.	Clarification	The DDA does not require participants to have a legal guardian.
10. Extraordinary Care by Legal Guardians a. Object to the requirement that a showing of a need for "extraordinary care" is required for legal guardians to work as staff and to the prohibition on legal guardians making decisions regarding service delivery if they work as staff.	Not accepted	States must select whether the waiver provides for extraordinary care payments to legally responsible individuals, legal guardians, and relatives for the provision of services. If selected, states must establish standards and ensure protection. For example, states must specify: (a) the types of legally responsible individuals, legal guardians, and relatives who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of services provided that is “extraordinary care” , exceeding the ordinary care

		that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services is in the best interest of the waiver participant; (d) the state processes to ensure that individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of services for which payment may be made; (f) any additional safeguards the state implements when services are provided; and, (g) the procedures that are used to ensure that payments are made only for services rendered.
11. Freedom of Provider Choice and Service Delivery Model a. Add clarifying language ensuring participants retain freedom to choose Self Directed Services unless due process criteria under 42 CFR § 431.220 are met.	Clarification	Participants have the choice of service delivery model as outlined in Appendix D. The Coordinator of Community Services provides information to each participant and their legally authorized representative, (as applicable), and other identified planning team members regarding available Medicaid waiver program services, service delivery models (i.e., Self-Directed Services and Provider-Managed Service Delivery Model), qualified providers, and availability of service providers.
12. Access and Informed Choice a. Mandate that access and informed choice be documented in writing, and any denial of Self Directed Services be subject to appeal.	Clarification	The choice of service delivery model is documented on the Freedom of Choice form and the Person-Centered Plan which is signed by the participant. The Maryland Department of Health provides a written letter notifying the individual of its denial decision including Notice: Medicaid Fair Hearing Rights.
13. Home and Community Based Settings Rule a. Add a formal complaint mechanism for participants	Clarification	The Maryland Department of Health's Office of Health Care Quality (OHCQ) handles complaints related to the quality of care

experiencing violations of these standards. b. Require annual setting reviews with participant and family feedback.		in Maryland community-based programs. You can file a complaint online by completing an online complaint form. If it is not possible for you to submit a complaint on-line, you may mail or fax the Paper Complaint Form. Coordinators of Community Services review settings annually as part of the person-centered planning process.
14. Independent Evaluation Of Compliance And Make Audit Findings Public a. Include reference to independent evaluation of compliance and make audit findings public	Clarification	The State oversight of compliance is noted within Appendix C and includes but not limited to: ● The Quality Improvement Organization, Office of Long Term Services and Supports, and Office of Health Care Quality review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations. ● The Quality Improvement Organization conducts a statistically statistical random sample in each region to confirm compliance with provider renewal requirements. The Quality Improvement Organization will also be sharing information at the Waiver Advisory Council Meetings. The Waiver Advisory Council provides input on: ● DDA-operated Medicaid waiver program system design; ● Service delivery and access to services; ● Federal waiver assurances; ● Ensuring Access to Medicaid Services (Access Rule); and ● Quality enhancement efforts and improvement strategies. The Quality Improvement Organization is exploring additional data summaries including statewide trends and quality improvement

		recommendations with significant impact on participants can be added to DDA's website. A scorecard is being developed by the Quality Improvement Organization to provide additional information on participants outcomes related to the following categories: ● Human Security ● Relationships ● Community ● Choices ● Goals The scorecard will also summarize participant experiences related to the following categories: ● Access to services ● Service delivery ● Case management ● Community inclusion ● Employment ● Self-direction The DDA will have further engagement with stakeholders to identify additional ways to share information with participants and families.
15. Home and Community-Based Settings Validation a. Include a summary of the validation methodology and indicate how participant voices were included.	Clarification	Information regarding the Home and Community-Based Settings oversight and monitoring is available on the DDA's Home and Community Based Services (HCBS) Final Rule website at https://health.maryland.gov/dda/Pages/HCBS.aspx.

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Assistive Technology Services

Assistive Technology Services		
Comment	**Department Comment**	**Department Response**
1. Service Requirements a. Include commercially available items such as, but not limited to, iPads and robotic lawn mowers as allowable under Assistive Technology services. b. Eliminate the requirement to obtain a denial from other programs for commercially available items such as but not limited to, iPads and robotic lawn mowers before accessing DDA funds to purchase these items. c. Include that a person can be approved for a replacement device once per year if new technology or changes in the person's needs require a different device or their device breaks and cannot be repaired. d. Clarify if device insurance and protection costs are allowable in the funding request. e. Clarify that communication access (such as ASL interpretation or support with speech-generating devices) is an essential component of equitable access to meaningful day support. f. Remove blanket exclusion of smartphones; allow based on the person centered plan justification. g. Provide reasonable accommodation procedures for individuals who cannot obtain three estimates or need expedited review. h. Require clear time limits and criteria for DDA "further	a. Clarification b. Not accepted c. Clarification d. Clarification e. Clarification f. Not accepted g. Not accepted h. Clarification i. Clarification j. Clarification	a. Assistive Technology means an item, computer application, piece of equipment, or product system as allowable under the waiver description and services standards. b. The Medicaid program functions as the payer of last resort. c. Services are based on assessed needs. d. Repair and maintenance of devices and equipment is covered. e. Speech and communication devices, also known as augmentative and alternative communication devices (AAC), such as speech generating devices, text-to-speech devices and voice amplification devices are covered. f. The waiver does not pay for smartphones and associated monthly service line or data cost. These items can be purchased by the participant with their own personal funds similar to the general public. However, there are many resources where people can access smartphones including: https://www.safelinkwireless.com/; Maryland Free cell phone providers: Access Wireless, American Assistance, Assist Wireless, Assurance Wireless, Cintex Wireless, Conexion Wireless, EnTouch Wireless, Life Wireless, Q Link Wireless, Safelink Wireless, Stand

justification" requests. i. Ensure service remains supplemental, not contingent on bureaucratic documentation barriers. j. Add language that allows for Person-Centered Plan teams to identify and access individualized remote support technologies as needed and appropriate for community-based activities, without duplicating the more systemic approach described in virtual supports or residential remote supports.		Up Wireless, Tag Mobile, Tempo Communications, Terracom Wireless, TruConnect, and US Connect. g. If the Assistive Technology, requested for the participant, has a cost that equals or exceeds $2,500, prior to acquisition of the Assistive Technology the participant must submit three estimates for the Assistive Technology and Services. h. The DDA will review and make a determination within 20-business days based on the Assistive Technology assessment and reasonable and customary costs. i. If the Assistive Technology requested for the participant costs up to, but does not equal or exceed $2,500, then an Assistive Technology needs assessment is not required, but may be requested by the waiver participant, prior to acquisition of the Assistive Technology. If the Assistive Technology requested for the participant has a cost that equals or exceeds $2,500, then an Assistive Technology needs assessment is required prior to acquisition of the Assistive Technology. j. The Medicaid waiver program will not fund any costs associated with the provider obtaining, installing, implementing, or using virtual supports, such as equipment, internet, software applications, and other related expenses. These costs, in the delivery of new business models, are part of the provider's operating cost.
2. SHIFT Enabling Technology Integration Specialist a. Maryland's waiver amendment explicitly should list the ETIS certification as the accepted credential from SHIFT. Enabling Technology Integration Specialist (ETIS) certification is for professionals who specialize in	Accepted	The amendment was updated to reflect Shift Enabling Technology Integration Specialist (ETIS) Certification.

integrating enabling technology, conducting assessments, implementing solutions, and mentoring staff. b. Clearly specify the SHIFT Enabling Technology Integration Specialist certification as a qualifying credential for Assistive Technology Professional conducting Assistive Technology and Remote Supports assessments.		
3. Assistive Technology Assessment a. Remove the requirement for an Assistive Technology assessment when a participant is requesting funding for a device or equipment they have previously used, and which is documented in an Individualized Education Program (IEP), Person-Centered Plan, or other documentation deemed appropriate by the DDA. The assessment requirement should apply only when the request is for new technology not previously used by the participant and not generally available to the public without disabilities. b. Allow participants to request and receive an Assistive Technology needs assessment when a goal on the Person-Centered Plan could potentially be addressed by an assistive technology assessment.	a. Not accepted b. Clarification	a. In order to ensure the best and most up-to-date technology to meet a participant's current assessed needs, if the Assistive Technology requested for the participant has a cost that equals or exceeds $2,500, then an Assistive Technology needs assessment is required prior to acquisition of the Assistive Technology. b. An Assistive Technology needs assessment may be requested by the waiver participant, prior to identifying the technology or cost.
4. Personal Emergency Response Systems (PERS) a. Do not remove Personal Emergency Response Systems (PERS) from the proposed waiver amendment. b. The Maryland Department of Health should find a way to incorporate Community First Choice funding for this service under the impacted participants' DDA Person-Centered Plan, rather than requiring a separate Community First Choice plan of service	Not Accepted	Prior to accessing DDA funding for this service, all other available and appropriate funding sources must be explored and exhausted to the extent applicable. Personal Emergency Response Systems is available through Community First Choice.

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5. Assistive Technology Services definition a. Revise the definition of Assistive Technology Services in the waiver amendment to reflect its essential role rather than labeling it as a creative solution. b. Assistive technology should be revised in both definition and implementation as a primary support option given its reliability, cost-effectiveness, and person-centered benefits. c. Assistive Technology should be elevated in definition and practice to a primary option, not a last resort. Technology solutions often provide reliable, cost-effective, and person-centered supports, especially critical during ongoing direct support workforce shortages. d. The proposed terminology shift to "Alert Support Devices" lacks clarity and may cause confusion around funding responsibilities	Clarification	The DDA received input on the revised language and will further engage with stakeholders for updates.
6. Assistive Technology and Remote Supports a. Consolidate Remote Supports Services and Assistive Technology into a single, unified service to allow participants streamlined access to the full range of technology supports they need. a. Clarify that devices installed in the participant's home to enhance safety, independence, or communication (e.g., Wi-Fi-enabled smoke alarms) fall under the Assistive Technology service category, distinguishing these from devices used by Remote Support providers to manage communication or service delivery on their end, which should fall under Remote Supports. This distinction is	Not Accepted	Assistive Technology and Remote Supports Services are two separate and distinct services. The DDA will consider this for future amendment, with stakeholder engagement.

essential for accurate planning and budgeting within the PCP.		
7. Assistive Technology Training a. Clarify the Assistive Technology Training policy to explicitly state that Assistive Technology Training is not limited to a one-time request. Ongoing Assistive Technology Training is necessary to address evolving vocabulary, language needs, staff turnover, functional usage, and to ensure that staff fully understand how to implement Assistive Technology devices across different environments. By clearly stating that Assistive Technology training can be requested multiple times as needed, the policy will provide clarity for reviewers and ensure continuous support for individuals using Assistive Technology. b. Require Coordinators of Community Services and Staff providing services to have training on Assistive Technology, such as Introduction to Assistive Technology and the Assistive Technology Navigator tool (how to navigate Assistive Technology services in MD) Reference: Assistive Technology Navigator - Maryland Inclusive Housing (MIH). c. Create alternative certification paths for self directed hires.	a. Clarification b. Not accepted c. Clarification	Assistive Technology Services include training or technical assistance for the participant and their support network including family members. It is not limited to a one time request. An Assistive Technology and Services manual will be created with input from stakeholders. The DDA will explore Assistive Technology training requirements for Coordinators of Community Services and providers with further engagement with stakeholders which can be considered for future amendment. c. Assistive Technology and Services is a budget authority services under the Self-Directed Service Delivery Model. Participants can hire a DDA-certified provider for services.
8. Assistive Technology Professionals a. Add Speech-Language Pathology Assistants as approved providers for Assistive Technology training. b. Expand the list of professionals qualified to assess and recommend Speech Generating Devices and other	Not accepted	The DDA will consider this for future amendment, with stakeholder engagement.

Assistive Technology to include: • Certified Assistive Technology Professionals credentialed by RESNA • Clinicians trained through accredited Assistive Technology certificate programs, such as CSUN's Assistive Technology Applications Program • Occupational Therapists, Physical Therapists, Special Educators, and other professionals with documented assistive technology ability, consistent with the person's needs • Speech-Language Pathologists when the primary purpose is to support communication b. Clarify that the type of qualified professional should align with the primary functional purpose of the device, not solely its technical features (e.g., speech output).		
9. Monthly Service Fees a. Agreement that Assistive Technology and Services fees-proposed to now include Monthly Service fees.	Accepted	The Department appreciates this feedback.
10. Waiver of Qualification Credentials a. Allow waiver by person-centered team if participant identifies qualified but non-credentialed support.	Not accepted	To support participants' health and safety and ensure qualified providers, the DDA has established specific professional standards, training requirements, and provider qualification requirements associated with each waiver service.

Community Pathways Waiver Amendment 2025
Public Comment Summary

Behavior Support Services

Behavior Support Services		
Comment	**Department Comment**	**Department Response**
1. Behavioral Supports Plan Template a. Maintain the clear requirements to ensure that participants are aware of what needs to be clearly identified in Behavior Support Plans to ensure timely access to appropriate services. An optional behavioral supports plan template would provide consistency and ensure providers clearly understand what information is needed	Not accepted	The DDA will consider this for future amendment, with stakeholder engagement.
2. Virtual Supports a. On pg. 7 combine subsections b. & c. of #8 to require Virtual Supports providers to develop a safety plan in case an emergency occurs during the provision of Virtual Support services. This safety plan should be specific to the participants' needs and identify needed interventions if an emergency occurs, such as the participant contacting 911 or identifying informal caregivers that may be available to assist. b. Broaden virtual service flexibility to accommodate individualized care delivery and technological access differences. c. Permit limited technology funding to ensure ADA/504	Not accepted	The provider must have written policies, train direct support staff on those policies, and advise participants and their person-centered planning teams regarding those policies that address: ● Identifying whether the participant's needs, including health and safety, can be addressed safely while they are using Supports provided virtually; ● Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the participant experiences an emergency; and

compliance and equity in access to virtual care		• How a person will get emergency interventions if the participant experiences an emergency, including contacting 911 if necessary. The Medicaid waiver program will not fund any costs associated with the provider obtaining, installing, implementing, or using virtual supports, such as equipment, internet, software applications, and other related expenses. These costs, in the delivery of new business models, are part of the provider's operating cost.
3. Revised Person-Centered Plan for Amended Behavioral Plan a. Clarify whether a participant needs to submit a new Person-Centered Plan if they amend their Behavioral Supports Plan.	Clarification	A Person-Cented Plan can be revised at any time if a person's needs change. If there are no changes in services, a revised Person-Centered Plan is not required. An amended Behavioral Support Plan must be shared with the Coordinators of Community Services and uploaded into the participant's file.
4. Clarify what will happen if the development and authorization of a Behavior Support Plan or Nursing Care Plan takes longer than 6 months.	Clarification	If the development and authorization of a Behavior Support Plan takes longer than 6 months, enhanced, or dedicated supports will not be authorized. The DDA may authorize Nursing Support Services in an Emergency Revised Plan for participants in services who have a specific, documented health and safety need to support the development Nursing Care Plan and subsequent request for dedicated support.
5. Language a. "Challenging" behaviors: i. Ensure consistent language referring to behaviors that warrant Behavioral Support Services and adopt an alternative to "challenging" behaviors. ii. A less pejorative term than "challenging"	a. Not accepted	a. The proposal refers to both "behavior" and "challenging behavior" in different areas as they refer to different aspects of a person's behavior. Not all behavior is "challenging"

behaviors should be adopted. iii. Clarify and specify what would constitute "challenging behaviors". As with other aspects of this comment, we are searching for clear and consistent language so that we can adequately adhere to any new rules and regulations. Any term that carries with it the potential ramifications of "challenging behaviors" needs to be clearly defined to avoid potential unintended consequences. b. On page 3, change #5 to remove the word, "pertinent": Providing ongoing education on recommendations, strategies, and next steps to the participant's support network (i.e., caregiver(s), family members, agency staff, etc.) regarding the structure of the current environment or a change to a different type of environment, activities, and ways to communicate with and support the participant, and enabling the participant to participate in ~~all pertinent~~ activities and environments to optimize the participant's community inclusion in the most integrated environment. c. Recommendation: On page 1, B1, strike "environmentals", and replace with "environments". The term "environmentals" is unclear.	b. & c. Accepted	b. The DDA will remove the reference to "all pertinent" activities and make the correction to the word, "environmentals."
6. Justification for dedicated supports a. Revise Behavioral Support Services to ensure that Behavior Support Plans include clear justification for dedicated 1:1, 2:1, enhanced, and overnight supports. This should include the following: • Detail the specific times support is needed, associated risks, and applicable mitigation strategies.	Accepted with amendment	The amendment currently includes: • Development of the Behavior Support Plan specific to the challenging behaviors, if applicable, with goals that are specific, measurable, attainable, relevant, time based, and based on a person-centered approach. Recommendations for dedicated 1:1 and 2:1 support, enhanced supports, and overnight services need to be clearly identified in the Behavior Support Plan including the specific times the

• Be developed using a person-centered approach with goals that are specific, measurable, attainable, relevant, and time-based. • If target behaviors are being effectively managed through the implementation of 1:1, 2:1, enhanced or overnight supports, then these strategies should be outlined in the plan, and the success of these interventions should serve as justification for their continued use. b. Reconsider this provision: page 2, h. Development of the Behavior Support Plan specific to the challenging behaviors, if applicable, with goals that are specific, measurable, attainable, relevant, time based, and based on a person-centered approach. Recommendations for dedicated 1:1 and 2:1 support, enhanced supports, and overnight services need to be clearly identified in the Behavior Support Plan including the specific times the supports are necessary, identification of risks, and mitigation strategies as applicable • If target behaviors are being maintained through strategies supported with 1:1, 2:1, or enhanced supports and these strategies are outlined in the behavior plan, this justification should support the continuation of these supports. • Often, behavioral data will decrease due to the success of these supports and reviewers will view this lack of data as justification for denial. The waiver should support successful strategy use as justification for the continuation of dedicated supports.		supports are necessary, identification of risks, and mitigation strategies as applicable. Strategies and guidance related to behaviors that are being effectively managed through the implementation of 1:1, 2:1, enhanced or overnight supports will be referred to the Positive Behavioral Support group for review and input.
7. Behavior Support Plan a. Do not limit participants to a single Behavior Supports Services provider, as it undermines the flexibility essential	Not accepted	The DDA Behavioral Support provider authorized shall support the participant across various environments and services including for both residential and meaningful day service, to provide a holistic

to person-centered service delivery. Comments received include but are not limited to: • Behavioral strategies and interventions used at home may significantly differ from those needed in community settings. Limiting a participant to a single behavior supports provider may hinder access to appropriate supports • The provider that develops the Behavioral Support Plan (BSP) is then responsible for training and ongoing monitoring of staff employed by a different agency, creating practical implementation, as well as liability issues, for the involved providers. • The provider that develops the Behavioral Support Plan may have a different perspective on the best way to support people with behavioral issues, resulting in a plan that does not have the support of the other supporting agency. • Often more than one provider, in order to best support the person, will develop Behavioral Support Plans, but only one of them is eligible for payment. • A person who requires behavioral support may need supports specific to an environment or activity. A home-behavioral support person may be focused on very different behaviors than a community-based behavioral support person.		and consistent approach to behavior supports. This includes assessments, consultations, and development of behavioral strategies in applicable environments.

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8. Provider Qualifications a. Retain the requirement for staff providing Brief Support Implementation Services to have a high school diploma or equivalent. Comments received include but are not limited to: ● This minimum education standard is essential for ensuring staff possess the necessary communication and problem-solving skills to deliver quality, safe behavioral support. ● Medicaid and commercial insurers require Board Certified Behavior Analysts, RBTs or licensed psychologists to provide behavior services for a reason: proper training in behavioral science is essential to fidelity in care. Diluting these standards for the sake of convenience does not serve individuals with complex needs. It minimizes the importance of quality, data-informed intervention. ● Removal of this will undermine the professional need for this type of worker. ● A high school diploma represents a reasonable and basic qualification to ensure safe and effective support. b. Consider a Masters Social Worker with 2 or more years of relevant experience to be able to develop a Behavior Support Plan. c. Expand the pool of eligible Behavior Support Service providers by allowing supervised trainees to deliver services under the license of a Board Certified Behavior Analyst (BCBA). Specifically, include the following roles: ● Board Certified Assistant Behavior Analysts (BCaBAs) ● Master's-level student behavior analysts completing supervised fieldwork	Not accepted	An individual is qualified to complete the Behavioral Assessment, Behavioral Support Plan, and Behavioral Consultation services if they have one of the following licenses: 1. Licensed psychologist; 2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology); 3. Licensed clinical professional counselor (LCPC); 4. Licensed graduate-level professional counselor working under the license of the LCPC; 5. Licensed Certified Social Worker-Clinical (LCSW-C); 6. Licensed masters-level social worker working under the license of the LCSW-C; 7. Licensed Behavioral Analyst (LBA); or 8. Board Certified Behavior Analyst (BCBA). In addition, an individual who provides the Behavioral Assessment and/or consultation services must have the following training and experience: 1. A minimum of 1 year of clinical experience under the supervision of a Licensed Health professional as described above, who has training and experience in functional analysis and tiered Behavioral Support Plans with individuals with intellectual and developmental disabilities; 2. A minimum of 1-year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and

● Bachelor's-level student behavior analysts completing supervised fieldwork. d. Revise provider qualification standards to balance rigor and accessibility, particularly for under-resourced communities.		3. Competencies in areas related to: a. Analysis of different styles of communication and communication challenges related to behavior; b. Behavior support strategies that promote least restrictive approved alternatives; c. Data collection, tracking and reporting; d. Demonstrated expertise with populations being served; e. Ethical considerations related to behavioral and psychological services; f. Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change; g. Measurement of behavior and interpretation of data, including ABC (antecedent-behavior-consequence) analysis including antecedent interventions; h. Identifying person-centered desired outcomes; i. Selecting intervention strategies to achieve person-centered outcomes; j. Staff/caregiver training; k. Support plan monitoring and revisions; and l. Positive behavioral supports and trauma informed care.

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		Staff providing the Brief Support Implementation Services must be a person who has: 1. Successfully completed a 40-hour behavioral technician training; and 2. Receives ongoing supervision by a qualified clinician who meets the criteria to provide the Behavioral Assessment and Behavioral Consultation. The DDA will engage with stakeholders to examine qualifications for Behavioral Support Providers for future amendments.
9. MANDT a. Clarify MANDT required training noted within the training matrix and the Meaningful Day Training policy and provide a 90-days timeframe for staff to complete.	Clarification	The DDA will review its policies to ensure standardization.
10. Behavior Support Services and Respite Care a. Allow Behavior Support Services to be provided during Respite Care to ensure the safety and effectiveness of supports for individuals with self-injurious or aggressive behaviors.	Not Accepted	The DDA will engage with stakeholders on policies related to Behavioral Support Services and Respite Care.
11. Medical Day Care a. Agree Behavior Supports to be provided to a person who also accesses Medical Day Care Services at the same time	Accepted	The Department appreciates this feedback.

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12. Frequency of Behavioral Support Services a. Clarify how often a Behavior Plan can be requested - annual per individual or once per provider with needed revisions and updates conducted under consultation	Clarification	Behavioral Assessment and Behavior Support Plan is limited to 1 per Person-Centered Plan year.
13. Behavioral Support Services and Direct Supports a. Allow simultaneous provision of behavior supports with direct services when clinically appropriate.	Clarification	Behavioral Support Services can be provided at the same time as other direct supports. Brief Support Implementation Services includes: onsite execution and modeling of identified behavioral support strategies. Staff must provide Brief Support Implementation Services on-site and in- person with the individuals supporting the participant in order to model the implementation of identified strategies to be utilized in the Behavior Support Plan
14. Exhaustion of Funding Prerequisite a. Remove exhaustion of funding prerequisite or replace with a more flexible, case-by-case documentation requirement that does not delay medically necessary care	Not accepted	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and appropriate funding sources must be explored and exhausted to the extent applicable.
16. Safeguards a. Clarify and strengthen rights safeguards including mandatory Human Rights Committee review, due process mechanisms, and participant notification.	Clarification	If the requested Behavioral Support Services, or Behavior Support Plan, restricts the participant's rights, as set forth in Title 7 of the Health-General Article of the Maryland Annotated Code or Code of Maryland Regulations Title 10, Subtitle 22, then the need for the restriction must be written in the participant's Behavior Support Plan in accordance with applicable regulations and policies governing restrictions of participant rights, Behavior Support Plans, and positive behavior supports. As per Code of Maryland Regulations 10.22.10.05:

		Before implementation, the licensee shall ensure that each behavior plan which includes the use of restrictive techniques is: (1) Approved by the standing committee as specified in COMAR 10.22.02.14E(1)(d); and (2) Includes written informed consent of the: (a) Individual; (b) Individual's legal guardian; or (c) Surrogate decision maker as defined in Health-General Article, §5-605, Annotated Code of Maryland. D. Before a licensee discontinues a behavior plan, the team and an individual appropriately licensed under Health Occupations Article with training and experience in applied behavior analysis shall recommend that the individual no longer needs a behavior plan.
17. Limitation a. Impose the same 40 hour per week/160 hour per month limitation to Behavioral Support Services.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

Career Exploration

Career Exploration		
Comment	**Department Comment**	**Department Response**
1. Service Prohibitions	Clarification	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and

a. Remove or streamline exhaustion of funding prerequisite to avoid unjustified delays in access. b. Clarify and narrow prohibition on simultaneous services to allow clinically appropriate combinations and avoid unjustified service gaps		appropriate funding sources must be explored and exhausted to the extent applicable. Career Exploration services are not available at the same time as the direct provision of Day Habilitation, Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Employment Services, Medical Day Care, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.
2. Self-Directed Authorities a. Permit participant-directed service options in alignment with the Centers for Medicare and Medicaid Services Home and Community Based Service requirements.	Not accepted	Career exploration is not a self-directed service option. Participants self-directing their services can access Employment Services.
3. Medically Complex a. Ensure protections for medically complex participants by removing categorical exclusions based on nursing or personal care needs.	Clarification	Career Exploration support all participants regardless of nursing care or personal care needs.
4.Qualified Providers a. Revise provider qualification standards to allow inclusive access for qualified but newer community-based organizations.	Clarification	Community provides and entities that meet the provider qualifications can apply to be a Medicaid provider of this service.
5. Community Integrated Employment Transition a. Clarify transition language and alignment with other services for individuals moving from existing service categories into Career Exploration.	Clarification	Career Exploration are time limited services to help participants learn skills to work toward competitive integrated employment. Career Exploration services are limited to up to 720 hours for the plan year. After receiving these supports, participants seeking employment should transition to Employment Services.

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Community Development Services

Community Development Services		
Comment	**Department Comment**	**Department Response**
1. Employment Services Concurrent Billing a. While Employment Services may not be billed concurrently with Community Development Services, an exception should be made for Discovery activities.	Not Accepted	The DDA will consider suggestions for future amendment, with stakeholder engagement.
2. Transportation a. If the waiver states that the service includes transportation to, from, and within, providers should be able to bill for the transportation time to and from the participants home, so long as transportation does not comprise the entirety of this service. *DDA has released guidance in the past that contradicts this. Providers should be able to bill for transportation time as stated in the waiver, or this should be clarified within the waiver.*	Clarification	Transportation is a component of Community Development Services including to community engagements, within the delivery of services, and returning back home. The time for staff to drive to the participants home or meet at a community location is not billable time, but costs are included in the hourly rate. Transportation to/from activities while within the same service is part of the Meaningful Day billable time.
2. Family Members a. Maintain the option for trained family members to provide Community Development Services to participants receiving services to: a. Reduce the systemic costs associated with the use of day programs.	Clarification	Relatives may provide Community Development Services.

b. Improve health outcomes for participants receiving services.		
3. Enrollment in Medicaid a. Do not require Community Development Services vendors to complete the DDA provider application process and enroll as Medicaid providers. This would include business plans, quality assurance plans, and licensing data. Community Development Services should remain flexible.	Not Accepted	Community Development providers must complete the provider application process and meet all qualification standards.
4. Services in facilities a. The DDA should clarify whether individuals receiving Community Development Services funding may participate in activities located in DDA-licensed provider facilities such as cooking classes not otherwise available in the community, if such participation is clearly documented as a personal choice in the individual's Person-Centered Plan. Allowing this flexibility would reduce administrative burden on staff and support individual choice without compromising the goals of community inclusion.	Clarification	Classes in DDA-licensed provider facilities do not meet the definition of Community Development Services. Cooking classes and other activities are available to the general public in a variety of settings.
5. Training a. Require all people providing Community Development Services to satisfactorily complete required orientation and training.	Not accepted	Providers are required to satisfactorily complete required orientation and training. Employees of participants in self-directed services are not required to complete this training, although a participant can require additional training of their employee.
6. Retirement a. Allow individuals receiving Community Development Services as a retirement service to spend a portion of their	Not accepted	Community Development Services are active supports in the community. A participant may choose to remain at home and not participate in Community Development Services. However,

day in their home with staff support, while still meeting the criteria for Community Development Services. This would allow individuals to move between their home and community activities during the day, reflecting a natural retirement lifestyle		time that they did not engage in Community Development Services would not be billable.
7. Enhanced Rate a. Recommendation to offer an enhanced Community Development Services rate	Not Accepted	Community Development Services includes dedicated 1:1 and 2:1 staff to participant ratio rates and a group rate.
8. Interim Supports a. DDA must affirmatively ensure interim supports under FAPE (if under 21), ADA, and Olmstead are provided without bureaucratic delay.	Clarification	Community Development Services are authorized based on assessed needs.

Community Living - Group Home Services & Community Living - Enhanced Supports Services

Community Living - Group Home Services & Community Living - Enhanced Supports Services		
Comment	**Department Comment**	**Department Response**
1. Remove the awake overnight requirement. Comments included but not limited to: a. Differentiate between "Awake" overnight 1:1 staffing and overnight supervision by staff available for emergencies	Accepted with amendment	Based on stakeholder feedback, the requirement for overnight supports to be awake and alert has been removed, for further discussions with stakeholders related to overnight supports.

and any issues that may arise recognizing that most individuals need staff 'available' b. Having staff present, but not necessarily awake, models sleep appropriateness, reduces chaos in the group home, reduces the need for sleep medications, reduces stimulation, requires less staff with the current Direct Support Professional (DSP) staffing shortage, and provides safety for individuals by having staff present. It also promotes a home-like environment compared to an institution c. Some people may need staff “on site and on call,” not all people need their staff to be awake while onsite, to be healthy and safe d. Requiring all staff to be awake does not take into account the person-centered needs of the individual, or the change in energy and dynamic that an awake overnight situation may incite, which may be considerably more institutional-restrictive and disruptive in nature than what may be required for the health and safety of a person receiving waiver services e. Allow services to continue as-is, around the clock for those who need monitoring and supervision, but creating a separate service of Awake Overnight that allows for an overnight pay differential to hire the appropriate staff. Legal guardians/relatives should not be eligible to work awake overnight f. If a person needs some supervision support overnight, but not necessarily Awake and Alert, they will have no option for overnight supports		Note: Participants with a Nursing Care Plan or Behavior Support Plan that required awake overnight staff must be provided by awake and alert staff as per the Nursing Care Plan or Behavior Support Plan.
2. Dedicated Supports a. On page 3 of the Community Living – Group Home in the Services Requirements section under D(2)(c), we encourage the department to clarify what will happen if	Clarification	If the development and authorization of a Behavior Support Plan takes longer than 6 months, enhanced, or dedicated supports will not be authorized. The DDA may authorize Nursing Support Services in an Emergency

the development of a Behavior Support Plan or Nursing Care Plan takes longer than 6 months.		Revised Plan for participants in services who have a specific, documented health and safety need to support the development Nursing Care Plan and subsequent request for dedicated support.
3. Residential Services for Participants under 18 a. DDA should authorize Community Living Group Home services for participants under 18 years of age when there is an assessed need.	Not Accepted	Community Living - Group Home Services are not available to participants under the age of 18.
4. Self-Directed Residential Services a. Clarify in the Self Direction Manual and the Community Pathways Waiver amendment whether an individual living in a DDA Provider group home can self-direct any of their services, and if so which ones. If not, please clarify why not	Clarification	Residential Services are not available to participants using the Self-Directed Service Delivery Model. The services are provided in a DDA-licensed site that is owned and operated by the provider.
5. Appeal Rights a. Add appeal rights or dispute resolution processes for Community Living Group Home- Enhanced supports	Clarification	The Maryland Department of Health informs the individual and their family or their legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA or the Maryland Department of Health. Reference: Appendix F
6. Clinical Review Or Quality Assurance/Quality Improvement Oversight a. Clarify the use of an independent clinical review or quality assurance/quality improvement oversight for authorizations of Community Living Group Home-Enhanced supports	Clarification	Community Living - Enhanced Supports provides the participant, who exhibits challenging behaviors or has court ordered conditions for release or probation supports. Participants will have (i) court ordered restrictions to community living; (ii) demonstrated history of severe behaviors requiring restrictions and the need for enhanced skills staff that are documented in a Behavioral Support Plan; or (iii) extensive needs that are documented in a Nursing Care Plan that require oversight.

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7.Remove "Challenging Behaviors" Language a. Remove stigmatizing and overbroad language related to court supervision and "challenging behaviors" in the approval of Community Living Group Home- Enhanced supports	Not accepted	Community Living - Enhanced Supports provides the participant, who exhibits challenging behaviors or has court ordered conditions for release or probation supports. Participants will have (i) court ordered restrictions to community living; (ii) demonstrated history of severe behaviors requiring restrictions and the need for enhanced skills staff that are documented in a Behavioral Support Plan; or (iii) extensive needs that are documented in a Nursing Care Plan that require oversight.
8. Safeguards a. Include procedural safeguards for denials and service authorizations, including appeal rights.	Clarification	The Maryland Department of Health informs the individual and their family or their legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA or the Maryland Department of Health. Reference: Appendix F
9.Qualified Providers b. Ensure provider qualification standards do not violate procurement or antidiscrimination laws by excluding newer providers.	Clarification	Community provides and entities that meet the provider qualifications can apply to be a Medicaid provider of this service.
10. Transition Supports and Trial Periods a. Clarify transition supports and allow for more flexible trial periods or cross-service coordination.	Clarification	As noted in the Residential Policy, a Trial Experience is available for individuals (either prospective or current participants) considering either Community Living – Group Home or Community Living – Enhanced Supports services. Trial Experience is a short-term stay with a potential DDA provider for the purpose of: ● Determine whether the participant and prospective DDA provider are compatible; ● Provide an opportunity for the participant to experience and understand the group home setting and gain confidence; and

		• Provide the DDA provider's direct support professionals an opportunity to be trained on the participant's specific support needs prior to his or her transition. A Trial Experience is available for individuals who are transitioning from: • An institutional setting; • Secure Evaluation & Therapeutic Treatment (SETT); • Homeless shelter; • Family home; or • Any other residential transition from a place that is not a Waiver or DDA funded group home.
11. Group Size and Dedicated Supports a. Add transparency to DDA discretionary decisions, especially around exemptions (e.g., group size, dedicated staffing).	Clarification	Individuals are supported better in smaller setting sizes. In 2015, the DDA issued a Group Home Moratorium noting the support of development of new homes to support up to four individuals. In support of the federal Community Settings Rule, the provider must ensure that the home and community-based setting in which the services are provided comply with all applicable federal, State, and local law and regulation, including, but not limited to, 42 Code of Federal Regulations § 441.301(c)(4), as amended. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participation ratio, enhanced supports, and overnight services: a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio, enhanced supports, and overnight services to support the person with specific behavioral needs; or b. The participant has an approved Nursing Care Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio, enhanced

		supports, and overnight services necessary to support the person with specific health and safety needs. c. The DDA may authorize dedicated support for participants new to services and participants in services who have a specific, documented behavioral need for up to 6 months while a Behavior Support Plan gets authorized and developed.
12. Rights To Choice, Integration, and Due Process a. Ensure participant rights to choice, integration, and due process are upheld throughout.	Clarification	In order for the Center for Medicare and Medicaid Services to approve a waiver, a state must make certain assurances concerning the operation of the waiver. These assurances are spelled out in 42 CFR § 441.302 and included in this part of the waiver application. In addition, other components of the amendment application address how the waiver is designed to meet these assurances and support choice, community integration, and due process.

Day Habilitation Services

Day Habilitation Services		
Comment	**Department Comment**	**Department Response**
1. Service Definition a. Recommendation: Either retain “any of the following” on page 1, line 1, or replace “and” with “or” on line 2 in the following sentence: Day Habilitation services provide the participant with the ~~any of the following~~ development and maintenance	Accepted	The service definition will be revised to read: Day Habilitation services provide the participant with any of the following development and maintenance of skills related to activities of daily living, instrumental activities of daily living, or vocation and socialization, through application of formal teaching methods and participation in meaningful activities.

of skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization, through application of formal teaching methods and participation in meaningful activities. Not everyone will need assistance with all areas identified in this section. The recommended language change will allow the person's supports to address their specific needs.		
2. Self-Directed Services Manual Revision a. Revise the Self-Directed Services manual to include: i. A distinction between Day Habilitation Services small group and dedicated 1:1 supports vendor rates. ii. Clarification if participants who receive Day Habilitation services in a small group setting can also access Day Habilitation services in a large group setting if they choose to do so.	Accepted	The Self-Directed Services Manual will be reviewed and updated.
3. Transportation a. Revise waiver language to clarify billing guidelines for providers who provide transportation services to and from the participant's home for Day Habilitation Services, to avoid confusion and ensure consistent application of waiver policies, given that transportation is included in the rate for Community Development Services.	Not accepted	Transportation is a component of Day Habilitation Services. The time for staff to drive to the participants home or meet at a community location is not billable time, but costs are included in the hourly rate. DDA created a visual guide in assisting stakeholders with understanding differences between transportation included in Meaningful Day Services and standalone Transportation Service. Day Habilitation Services billing begins when the participant arrives at the licensed site or community engagement as applicable.

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Employment Services

Employment Services		
Comment	**Department Comment**	**Department Response**
1. Discovery Profile - Direct and Indirect Supports a. Provide more flexibility and clarity regarding the indirect / direct ratio for job development. b. Direct in-person service minimum percentage of time should initially be set at a minimum of 25% of the time with guidance on how providers may show compliance with this standard easily for billing compliance. c. Clarify whether the indirect/direct service ratio for job development applies at the individual or program level. In light of new federal work requirements, we also request detailed guidance and flexibility to ensure individuals are not denied services due to regulatory changes	Not accepted	As per the Meaningful Day Services policy: • Effective March 13, 2023, DDA recognizes, based on national best practices, Competitive Integrated Employment (CIE) outcomes, and practical realities, Job Development is a strategic combination of both direct and indirect services. Direct service job development should entail at least 50% of this service. Indirect service can entail up to 50% of this service but needs to be directly related to the person's job related outcomes. • When billing for job development, it should be clearly documented what indirect service was provided, duration of service, and for whom. Specifically, there should be a clear indication of what was direct and indirect and a clear accounting of time to ensure it does not exceed the 50% threshold of indirect service time. The DDA will seek stakeholder input related to additional flexibility and clarity regarding job development indirect and direct supports.
2. Services Limitations a. Increase flexibility in the authorization of Job Development hours by allowing allocations based on individual need, especially for participants with limited	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

work experience or who require customized employment. b. Increase flexibility in the authorization of Employment Services-Job Development hours to ensure: i. The authorization is based on individual need and not capped at 90 initial hours, ensuring that participants with limited work experience or those needing customized employment can utilize the service. ii. A reduction in the number of revised person-centered plans to access additional job development hours, which often creates delays for participants.		
3. Training exemption a. The DDA should exempt current employees providing employment services under the Self-Directed Services model of service delivery from all related training. Requiring these trainings without any financial or logistical support may place a burden on staff and disrupt participants' services. b. The DDA should cover the cost associated with training staff who provide Supported Employment services to participants.	Not accepted	Employees of participants using the Self-Directed Service Delivery model must meet required qualifications. The cost of training is included in the rate.
4. Follow-Along Supports a. Revise the language in the proposed waiver amendment as it pertains to Employment Services-Follow Along to improve clarity and consistency. a. Remove the term "face-to-face" and refer to the requirement as "support contacts". These should be defined as face-to-face by default, unless the participant's Service Implementation Plan (SIP) includes documentation approving virtual supports.	Not accepted	Follow-Along Supports include at least two direct face-to-face support contacts with the person in the course of the month, but may also include other types of interventions, such as, but not limited to: • Phone calls to the person and/or employer; and • General coordination needed to support a person to maintain their employment.

b. Virtual support preferences should be documented in the Service Implementation Plan, not the Person-Centered Plan c. Follow Along #3 includes at least two direct face to face support contacts; yet #5 states direct support contacts can be completed using virtual supports as indicated in the PCP.		Virtual support must be documented in the Person-Centered Plan and in the Service Implementation Plan.
5. Service Flexibility a. Participants actively engaged in job seeking through Job Development should be allowed to proactively request Employment Ongoing Supports and Employment Follow-along Supports in their annual person-centered plans, regardless of the duration of their job search. b. Participants should continue receiving services for one additional year if still unemployed after the first year. After two consecutive years without employment, they should not be authorized for further services unless they first secure employment. c. Not allowing participants who have been authorized for ES – Follow Along and/or ongoing for 2 previous plan years without securing employment to be authorized unless the person obtains employment creates a barrier when they finally do get a job to being able to start it. Submitting revised plans every time people get a job will create an administrative burden and delay for the person. d. Keep the service flexibility for requesting all employment services a person may need in the annual plan, regardless of whether a participant has secured employment. e. Participants new to employment services should be authorized to use the service even if not currently employed. f. If a participant secures employment mid-year, a revised Person-Centered Plan should be submitted and marked as	a. Not accepted b. Accepted c. Not accepted d. Not accepted e. Clarification f. Clarification	a., b., c, and d.. Participants who have been authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports for one (1) previous plan year without securing employment during the previous plan year, may be authorized these services for one (1) additional plan year even if the participant is not currently employed. Participants who have been authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports for two (2) consecutive plan years without securing employment, may not be authorized these services for any subsequent plan year unless the participant secures employment. e. Participants who have newly added an employment goal, including participants new to service, Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports may be authorized even if the participant is not currently employed. e. If a participant subsequently secures employment during the course of their plan year, and this employment is assessed to require these services, the Coordinator of Community Services must submit a Revised Person-Centered Plan marked as urgent.

"urgent".		
6. Discovery a. Make an exception for Community Development Services from the list of services that are not available at the same time as Discovery services.	Not Accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
7. Employee competencies a. To meet the goal of employment services and increase the number of people with developmental disabilities working, all Direct Support Professionals, including those providing services for people who self-direct, should meet competencies.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
8. Direct/In-Direct Time Percentages a. Allow flexibility in the percentage of in-person work based on individual circumstances, especially rural areas, remote work roles, or participants for whom in-person meetings may pose a barrier. b. Clarify that the quality and outcome of job development efforts is the primary measure of effective service delivery rather than a fixed percentage of in-person time	Not accepted	Job Development supports direct and indirect Supports – Strategic combination of both direct and indirect services. Direct service job development should entail at least 50% of this service. Indirect service can entail up to 50% of this service but needs to be directly related to the person's job related outcomes.
9. Ongoing Job Supports a. Add the phrase "but not limited to" to ensure language is flexible enough to meet a person's changing needs.	Not accepted	Ongoing Job Supports are supports in learning and completing job tasks either when beginning a new job, after a promotion, or after a significant change in duties or circumstances and individualized supports a participant may need to successfully maintain their job. Ongoing Job Supports include:

		1. Job coaching (e.g., job tasks analysis and adaptations, self-management strategies, natural and workplace supports facilitation, and fading assistance), needed to complete job tasks like setting up workstations; 2. The facilitation of natural supports in the workplace; 3. Systematic instruction and other learning strategies based on the participant's learning style and needs; 4. Travel training to independently get to the job; and 5. Personal care assistance, behavioral supports, transportation, and delegated nursing tasks to support the employment activity. 6. Direct support may be provided on and off the employment site.
10. Milestone Minimum Standards a. Each employment milestone should have a minimum list of what should be captured during this phase as standards and documentation requirements for completion. Additional items can be included, but minimum standards should be spelled out.	Clarification	Milestone #1 includes: • Documentation of a visit/observation with the participant and their team in the participant's home or in an alternate and mutually decided upon location aside from a provider site; • Documentation that the visit included discussion of the participant's interests and preferred activities or hobbies, including how they spend their time; • An in-person survey of the community near and around the participant's home; • Record reviews for pertinent job experience, education, assessments; • Documentation of other collaboration with other pertinent team members; and • Completion of Discovery Milestone #1 Profile. Milestone #2 includes

		• An individualized skill assessment, learning and teaching style identification through community-based task trials; • A minimum of three (3) job trials and/or community skills observation; and/or informational interviews with area employers; • Documentation of what has emerged and what was learned from the job trials, community skills observations, and informational interview; • Documentation of team discussions and coordination; and • Completion of Discovery Milestone #2 Profile. Milestone #3 includes: • Compilation of information collected to-date, any additional activities that have occurred within Discovery; • A final summary outlining who the participant is; • Written and/or visual resume; • A person-centered planning team meeting and/or collaboration with other pertinent team members to compile all information into a final Employment Plan which includes recommended next steps and action items; and • Completion of Discovery Milestone #3 Profile.
11. Milestone #2 a. The term "skills assessment" is inconsistent with the principles of Discovery. Discovery is not an assessment but a process of learning about a person's interests and strengths without comparing them to normative standards.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

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12. Milestone #3 a. The phrasing should be changed from "include" to "can include" to reflect flexibility and person-centeredness	Not accepted	Milestone #3 includes: • Compilation of information collected to-date, any additional activities that have occurred within Discovery; • A final summary outlining who the participant is; • Written and/or visual resume; • A person-centered planning team meeting and/or collaboration with other pertinent team members to compile all information into a final Employment Plan which includes recommended next steps and action items; and • Completion of Discovery Milestone #3 Profile.
13. Language discrepancy a. Under Section R, "employment services are not available at the same time," we recommend clarifying that this refers specifically to ongoing services not being available while Community Development Services or Day Habilitation services are provided. As Follow along is a milestone, the scope and duration of service can be provided with other services.	Clarification	Employment Services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Day Habilitation, Medical Day Care, Personal Supports, Respite Care Services, or Transportation (except during follow along supports) services.
14. Training requirements a. We recommend outlining the specific training required (A-E) in the waiver amendment for clarity and consistency. In Employment Services Professionals, Section d.(1): Follow Along and Ongoing Supports, the standards should clearly state that if a job coach does not hold their Certified Employment Support Professional (CESP) credential, they must complete designated core training	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

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Environmental Assessment Services

Environmental Assessment Services		
Comment	**Department Comment**	**Department Response**
1. Annual Assessment a. Eliminate the requirement for annual reassessment of long-term technology needs when the equipment is expected to remain in use beyond one year.	Clarification	An annual assessment is not required if the participant is not requesting additional modification.

Environmental Modification Services

Environmental Modification Services		
Comment	**Department Comment**	**Department Response**
1. Automatic Approvals a. Revise the service guidelines for environmental modifications to include that once approved in a participant's PCP and budget, these items are consistently funded to avoid delays that compromise safety.	Not accepted	The annual Person-Centered Plan can be authorized for environmental modifications based on the participant's need.

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2. Installation and Maintenance a. Clarify whether installation and maintenance costs are covered.	Clarification	Installation and maintenance are covered for grab bars, detectable warnings on walking surfaces, and lifts and stair glides. Service and maintenance of the modification and training on use of modification are also covered.
3. Smart Home Devices a. Support the inclusion of SMART home devices such as voice-activated door openers, as covered services under environmental modifications b. To improve clarity, please specify whether costs for devices like smartphones, tablets, and ongoing subscriptions are included c. Consider expanding coverage to include more affordable smart devices to enhance accessibility for all individuals d. Include small smart home devices (such as Amazon and Google hubs) and clarify what costs are covered. e. Since there are so many options for smart home devices, allow the approval in the PCP to be case-by-case.	a. Accepted b. - d. Not accepted e. Clarification	The Department appreciates this feedback. b. - d. The DDA will consider these recommendations for a future amendment, with stakeholder engagement. e. Services are approved based on assessed needs.

Family and Peer Mentoring

Family and Peer Mentoring		
Comment	**Department Comment**	**Department Response**
1. Provider Qualifications a. Agree with removing the bachelor's degree requirement in the Other Standard's section. Given that one's formal education is not reflective of the experience one has for	Accepted	The DDA appreciates this feedback

caring for a loved one, the removal of this requirement is vital for removing barriers to providing care.		
2. People with Lived Experiences a. Include family members in the definition of people with "lived experience."	Clarification	Individuals with disabilities are considered people with "lived experience." Family Mentors are considered to have lived experience in caring for and supporting a family member with intellectual and developmental disabilities to help them live their best life.
3. Lived Experience a. Agree with DDA recognizing the value one can offer if they have lived experience and skills to provide caregiving services. This experiential knowledge is key to increasing access to quality care.	Accepted	The DDA appreciates this feedback

Family Caregiver Training and Empowerment Services

Family Caregiver Training and Empowerment Services		
Comment	**Department Comment**	**Department Response**
N/A		

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Housing Support Services

Housing Support Services		
Comment	**Department Comment**	**Department Response**
1. Virtual Housing Support Services a. Consider the flexibility which providing this service remotely provides to participants. b. Retain Remote Delivery of Housing Support Services. c. Consider cost savings associated with transportation and mileage reimbursement through the provision of Housing Support Services remotely. d. Consider equitable access to Housing Support Services for those who may otherwise face barriers due to scheduling or location e. Continued allowance for the virtual delivery of housing-related services, which are largely indirect in nature and well-suited for virtual delivery. f. Remote support options should not replace in-person supports but supplement them.	Accepted	Housing Support Services includes both direct and indirect support for the participant. The virtual support delivery model will be added.

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Individual and Family Directed Goods and Services

Individual and Family Directed Goods and Services		
Comment	**Department Comment**	**Department Response**
1. Expand to Participant Using the Provider Managed Model a. Create greater-health equity between people who choose the provider model vs. the self-direction model by addressing the ability of people who choose providers to have coverage for health-related services that are not otherwise covered by insurance. b. Allow Individual and Family Directed Goods and Services to be offered under the Provider Managed Model.	Not accepted	As per the Center for Medicare and Medicaid technical guide, Individual and Family Directed Goods and Services service is limited to budget authority in participant directed services.
2. Allowable Items a. Simplify the guidelines for what may be approved. b. Do not limit the scope of what activities can be paid . c. Include YMCA memberships. d. Allow social activities to be covered.	Clarification	Individual and Family Directed Goods and Services includes: • Fees for community programs and activities that are inclusive, promote socialization and independence. Individual and Family Directed Goods and Services does not include: • Programs and activities that are exclusive for individuals with disabilities. The DDA will seek to further simplify.
3. Reasonable and Customary a. Define reasonable and customary under Individual and Family Directed Goods and Services.	Clarification	Reasonable and customary cost for goods and services refers to the price or fee that is typical and generally accepted for a particular item

		or service in a specific geographical area, given the prevailing market conditions.
4. Emergency Request a. The waiver amendment does not address how emergency Individual and Family Directed Goods and Services requests should be handled.	Not accepted	Individual and Family Directed Goods and Services should not meet emergency needs.
5. Programs Exclusively for People with Disabilities a. Revise the current language in the proposed waiver amendment for Individual and Family Directed Goods and Services to allow funding for programs that are exclusively for individuals with disabilities.	Not accepted	Appendix C-5: Home and Community-Based Settings Requirements includes: Requirement for services to be integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid home and community-based services This means settings must be integrated in and support full access to the broader community, offering opportunities for meaningful interaction with people both with and without disabilities.
6. Service Limit a. Remove the proposed $5,000 cap on Individual and Family Directed Goods and Services. b. Allow participants with cost savings in their budget to apply these funds towards approved goods and services which supports their unique service needs and goals. c. Allow exceptions or create other funding avenues for extraordinary needs, to avoid harmful service denials. d. Extend the $5,000 cap to $7,000 for Individual and Family Directed Goods and Services per plan year.	Not accepted	The Budget Reconciliation and Financing Act 2025 removes the restriction on the DDA's ability to limit the dollar amount of Individual Family Directed Goods and Services (IFDGS). The Waiver was amended to re-establish the $5500 limit (includes $500 for recruitment and advertisement).

e. Allow for an exception process above the cap. f. Exclude program costs from cap. g. Establish a cap on goods and services only.		
7. Partial Insurance Coverage a. Revised language to support funding when a portion of the service is covered by health insurance, the waiver will cover the remaining cost.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
8. Day-to-Day Administrator Service Hours a. Do not impose a 10-hour per month cap on the Day-to-Day Administrator role. b. Establish criteria for how day-to-day administrative hours are authorized so that people with enhanced support needs are authorized for more of this service. c. Establish enhanced criteria and rate that would include up to 10-hours per week. d. Establish an exception process for requests above 10-hours per month.	Not accepted	The hours were capped at 10-hours per month to allow as many participants as possible to access this service without going over what was appropriated ($7 million).
9. Day-to-Day Administrator a. Make the Day-to-Day Administrator role a standalone service from Individual and Family Directed Goods and Services.	Not accepted	The DDA consulted the Center for Medicare and Medicaid Services on the development of the Day-to-Day Administrative Support services and was advised to keep within Individual and Family Directed Goods and Services for the self-directed service delivery model.
10. Day-to-Day Administrator Duties a. Do not restrict the duties of the Day-to-Day Administrator role. The DDA should consider how these restrictions will severely limit the effectiveness of this service by making it	Not accepted	The DDA-operated Medicaid waiver programs and Medicaid State Plan include a variety of services to support needs for all participants. Examples include but not limited to: Coordination of Community Services, Housing Support Services, Personal Supports, Community Development Services, Support Broker Services, Financial

unusable for many participants, especially those without able-bodied guardians. b. Convene a stakeholder workgroup to establish best practices for Day-to-Day Administrative Services. c. Allow the scope of the Day-to-Day Administrative Supports to include: i. Household management and scheduling. ii. Employee scheduling. iii. Personal money management. iv. Bill paying assistance. v. Ensures consistency and quality of care.		Management and Counseling Services, HealthChoice Special Needs Coordinator). A team decision tree checklist for household management tasks and medical appointment scheduling shall be completed to identify needs. The decision tree checklist shall include: i. Individualized task list of household and personal management specific to the participant; ii. Identification of tasks the participant can do for themselves with or without assistance from other supports such as natural supports, health insurance health coordinator, supported decision making agreement, Medicaid and waiver services; representative payees, or guardian of person or property; iii. Identification of support, training, or education available for the participant to learn to complete tasks on their own or with the support of natural supports, supported decision making agreement, or direct support staff; iv. Identification of current team members that can assist with task; v. Identification of other waiver services that can assist with task; vi. Identification of local, State, and federal programs and resources that can assist with task; and vii. Identification of unmet needs that are within the Day-to-Day Administrative Supports service for which an employee can be hired.
11. Day-to-Day Administrative Services - Parent and Guardian Paid Providers a. Do not allow Day-to-Day Administrative Services to be provided by parents.	Not Accepted	Relatives can provide Day-to-Day Administrative Supports if they are not also a legal guardian or legally responsible person. The DDA will consider these recommendations for a future amendment, with stakeholder engagement.

b. Allow parents or guardians to be Day-to-Day Administrators. c. Allow parents of minors to provide Day-to-Day Administrative Supports to their children.		
13. Day-to-Day Administrative Supports Provider Benefits a. Day-to-Day Administrative Supports providers should not be offered benefits.	Clarification	Individual and Family Directed Goods and Services does not include staff benefits.
14. Day-to-Day Administrative Supports - Elimitate a. Eliminate Day-to-Day Administrative Supports, since Personal Support Services staff can perform those functions along with natural supports.	Not accepted	The Fiscal Year 2026 Budget Bill creates this new service. Day-to-Day Administrative Supports cannot be authorized if they are available under another Medicaid State Plan or Medicaid waiver service (e.g., Coordination of Community Services, Housing Support Services, Personal Supports, Community Development Services, Support Broker Services, Financial Management and Counseling Services, HealthChoice Special Needs Coordinator). Day-to-Day Administrative Supports does not include: Personal Supports Services including budgeting and money management; maintaining a home (e.g. cleaning out refrigerator, ensuring paper products, etc.); meal preparation; personal care; house cleaning/chores; laundry; and overnight supports.
15. Day-to-Day Administrative Supports Limitation a. Add verbiage to Day-to-Day Administrative service that they cannot be another paid role for the same participant.	Clarification	The proposal notes individuals providing Day-to-Day Administrative Supports may not provide any other Medicaid waiver program service to the specific participant they are supporting with Day-to-Day Administrative Supports.
16. Other Funding Sources	Not Accepted	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and

a. Eliminate the requirement for families to exhaust other funding sources when the service is already recognized as an approved waiver expense.		appropriate funding sources must be explored and exhausted to the extent applicable.
17. Day-to-Day Administrator Maryland Residency a. Eliminate the requirement for the Day-to-Day Administrator to live in Maryland.	Not Accepted	Day-to-Day Administrative Supports provider must live in the state of Maryland by owning or renting a place to live in Maryland and continuously occupying it
18. Individual and Family Directed Goods and Services a. Reconsider the limitations being proposed on the types of items which can be covered or purchased under Individual and Family Directed Goods and Services. b. Restore language to allow for reasonable purchases of memberships, classes, etc. if the activity's purpose is habilitative and supports a documented goal in a person-centered plan, pending review and approval. c. Add the requirement that the person-centered planning process must include exploration of inclusive, integrated activity opportunities and ensure informed decision-making. If a participant chooses disability-specific classes, activities, events, or programs, the person-centered plan must document that integrated and inclusive activity options were explored and chosen along with disability-specific opportunities. d. Strike subsection G(36) on page 5: "Programs and activities that are exclusive for individuals with disabilities," and instead describe specific criteria that would constitute improper segregation of a Waiver participant from the community. e. Specify and make explicit reference to the data it will utilize to determine whether the cost of a requested Individual and Family Directed Goods and Services benefit is "fair and typical" for the requested service or product.	Not Accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

f. Convene a stakeholder workgroup to review cost, benefits, and equity regarding IFDGS. g. Strike "memberships" for recreational activities from the proposed list of goods and services that are excluded from Individual and Family Directed Goods and Services. h. On page 9, under Service Requirements section S remove "Individual Family Directed Goods and Services requests cannot be submitted if the participant does not have an active and approved Initial, Revised or Annual, approved self-directed Person-Centered Plan". i. Include a clear definition of "diversional" or "recreational" activities. j. Allow funding for programs for individuals that are exclusively for people with disabilities.		
19. Day-to-Day Administration Supports Transition a. Allow families with an already approved Day-to-Day administrator for participants living independently to continue their services without any changes, to prevent any disruptions in care and crises.	Not accepted	Effective October 6, 2025, participants currently approved Individual and Family Directed Goods and Services above this limit can continue to utilize the authorized amount through the end of their plan year.
20. Day-to-Day Administrative Supports 40-hour Limit a. Remove proposal that the Day-to-Day Administrative Supports providers can provide collectively for all participants they support up to 40 hours per week of Day-to-Day Administrative Supports	Accepted with amendment	The proposals for limiting Day-to-Day Administrative Supports providers to provide collectively for all participants they support up to 40 hours per week of Day-to-Day Administrative Supports services will be removed from the amendment for further discussions with stakeholders.
21. Dental Work	Accepted	The Department appreciates this feedback. Individual and Family Directed Goods and Services to include dental services recommended by a licensed dentist and not covered by health

a. Agree that Individual and Family Directed Goods and Services to include addition of dental work not covered by other insurances.		insurance such as dental anesthesia and denture services not covered by health insurance.

Live-In Caregiver Supports

Live-In Caregiver Supports		
Comment	**Department Comment**	**Department Response**
1. Code of Federal Regulation Reference a. On page 1, reinstate Service Requirement section B "Live in Caregiver Supports must comply with 42 C.F.R. § 441.303(f)(8) and be approved by the DDA."	Not Accepted	The Center for Medicare and Medicaid Services advised the State the reference was not needed.

Medical Day Care

Medical Day Care		
Comment	**Department Comment**	**Department Response**
1. Access to Medical Day Care a. The availability of Medical Day Care does not necessarily allow sufficient or appropriate community integration under a person-centered plan for those who receive Rare and Expensive Care Management services.	Clarification	Medical Day Care (MDC) services provides medically supervised, health-related services in an ambulatory facility setting, as defined in Code of Maryland Regulations 10.09.07. The service includes activities programs developed by the provider.

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Nursing Support Services

Nursing Support Services		
Comment	**Department Comment**	**Department Response**
1.Provider Qualifications a. Finger prints, background checks, notarization, CPR certification, should not be required for Nursing Support Services.	Not accepted	To support participants' health and safety and ensure qualified providers, the DDA has established specific professional standards, training requirements, and provider qualification requirements associated with each waiver service.
2. On-Call 24/7 a. Support statements throughout the document that nurses do not have to be on-call 24/7 but must be able to timely respond to calls for assistance in accordance with regulations.	Accepted	The DDA appreciates this feedback.
3. Other Resources a. Recommending that nursing support services should not be the sole resource for individuals with dysphasia, assessed feeding and swallowing issues, at risk of choking, meeting nutrition needs of individuals with assessed dietary issues i.e. diabetes, over or underweight, etc.	Clarification	The DDA-operated waivers offer various meaningful day, support, and residential services to support assessed habilitative needs. Participants can receive services based on their needs and goals.
4. Nutritional Needs a. Nurses should not be expected to manage nutritional needs, as licensed dieticians are the professionals qualified	Clarification	Registered nurses may provide a Nursing Assessment, Nursing Care Plan, Nurse Consultation services, Health Case Management services, and Delegation services.

to assess and recommend specialized diets		
5. Service Coordination a. Full training and education should be provided to people about interfacing with Rare and Expensive Case Management services, Community First Choice, and other services with DDA nursing.	Accepted with amendment	The DDA will partner with Rare and Expensive Case Management services, Community First Choice, and other services to provide informational webinars.
6. Rare and Expensive Case Management a. Strike the language stating that Rare and Expensive Case Management participants who receive Private Duty Nursing are not qualified to receive funding for Nursing Support Service, and replace it with language that allows Rare and Expensive Case Management participants whose Private Duty Nursing allocations are less than 168 hours/week may be eligible for Nursing Support Services under the waiver to receive Nursing Support Services "unless otherwise authorized by the DDA." b. Alternatively, the DDA could pay for Home Health Agency services to do an OASIS evaluation and provide appropriate supplemental delegated nursing to Rare and Expensive Case Management participants.	Not Accepted	A participant cannot qualify, or receive funding for Nursing Support Services if the participant: • Requires provision of direct nursing care services provided by a licensed nurse; or • Currently receives, or is eligible to receive, nursing services in another health care program paid for by the Maryland Medicaid Program or the Department, such as hospital services, skilled nursing or rehabilitation facility services, or Medicaid Program's Rare and Expensive Case Management Program's private duty nursing services. The DDA does not provide or pay for Home Health services.
7. Direct Skilled Nursing Services a. Add new non-delegable nursing services (Skilled or "Direct" Nursing Services) should be a stand-alone service with an adequate funding rate.	Not Accepted	The DDA-operated Medicaid waiver programs provide habilitative community-based services and supports. The Nursing Support Services includes nurse consultation, health case management and delegation services. They do not include skilled private duty nursing.
5. Nurse Delegation a. Require documented nurse delegation with safeguards and	Accepted with amendment	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

training standards.		
6. Limitation b. Impose the same 40 hour per week/160 hour per month limitation to Nursing Support Services.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

Participant Education, Training, and Advocacy Supports

Participant Education, Training, and Advocacy Supports		
Comment	**Department Comment**	**Department Response**
1. Frequency of Verification of Organized Health Care Delivery System a. Add the Frequency of Verification of Organized Health Care Delivery System to continue thereafter at least every 3 years.	Clarification	MDH will verify initially that the Organized Health Care Delivery System meets qualifications prior to being certified. Organized Health Care Delivery Systems must verify service providers meet all required qualifications prior to service delivery and continuing thereafter.
2. Funding Limits a. The waiver language currently states funding is limited to up to $500 per participant per plan year. However, the LTSS rate chart states an upper limit of $1,595. These two figures are inconsistent and may lead to confusion in service planning and authorization. b. Review and align the maximum allowable amounts for both services to ensure consistency across waiver	Clarification	Participant Education, Training and Advocacy Supports is limited to 10-hours of training per participant per plan year. The amount of training or registration fees for registration costs at specific training events, workshops, seminars, or conferences is limited to $500 per participant per plan year. The LTSSMaryland rate chart reflects the upper service limit for authorization.

documentation and the LTSS rate chart. c. Eliminate the hourly service limit and retain only the upper dollar limit to allow greater creativity in service delivery and responsiveness to participant learning styles and goals.		
3. Provider Qualifications a. Do not limit providers of Participant Education, Training, & Advocacy and Family Caregiver Training & Empowerment to Organized Health Care Delivery Systems b. Ensure that the added requirement that "anyone paid to provide a Medicaid waiver service is considered a Medicaid provider" does not preclude a person from using this service to attend a training or education event provided by any disability organizations. c. This amendment proposes under the section participant training and education limiting this service to those who are "an organized healthcare delivery system" by imposing this limitation restricting the organizations that can provide the service to what in plain language means someone who is licensed to provide at least one Medicaid service the administration removes the ability of groups like People on the Go or Autism on the Go and others who have lived experience as people with disabilities from providing this training. People with disabilities learn best from their peers, please remove this language from this amendment.	Clarification	Participant Education, Training and Advocacy Supports provides *funding* for the costs associated with training programs, workshops, and conferences to assist the participant in developing self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. The participant identifies and requests funding for training programs, workshops, and conferences in developing self-advocacy skills, exercising civil rights, and acquiring skills needed to exercise control and responsibility over other support services. The training programs, workshops, and conferences can be provided by community organizations including People on the Go, Autism on the Go, and others and will be paid for by the Organized Health Care Delivery Systems.

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Personal Supports

Personal Supports		
Comment	**Department Comment**	**Department Response**
1. Awake Overnight Requirements a. Remove awake overnight requirement. b. Differentiate between "Awake" overnight 1:1 staffing and overnight supervision by staff available for emergencies and any issues that may arise recognizing that most individuals need staff 'available' c. Having staff present, but not necessarily awake, models sleep appropriateness, reduces chaos in the group home, reduces the need for sleep medications, reduces stimulation, requires less staff with the current Direct Support Professional (DSP) staffing shortage, and provides safety for individuals by having staff present. It also promotes a home-like environment compared to an institution d. Some people may need staff "on site and on call," not all people need their staff to be awake while onsite, to be healthy and safe e. Requiring all staff to be awake does not take into account the person-centered needs of the individual, or the change in energy and dynamic that an awake overnight situation may incite, which may be considerably more institutional-restrictive and disruptive in nature than what may be required for the health and safety of a person receiving waiver services	Accepted with amendment	Based on stakeholder feedback, the requirement for overnight supports to be awake and alert has been removed, for further discussions with stakeholders related to overnight supports. Note: Participants with a Nursing Care Plan or Behavior Support Plan that required awake overnight staff must be provided by awake and alert staff as per the Nursing Care Plan or Behavior Support Plan.

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f. Allow services to continue as-is, around the clock for those who need monitoring and supervision, but creating a separate service of Awake Overnight that allows for an overnight pay differential to hire the appropriate staff. Legal guardians/relatives should not be eligible to work awake overnight g. If a person needs some supervision support overnight, but not necessarily Awake and Alert, they will have no option for overnight supports		
2. 82-Hour Service Limit Removal a. Changes in the waiver amendment are especially positive in supporting quality supports by community providers, resulting in improved outcomes for individuals b. Do not limit Personal Supports to 82-hours.	Clarification	Personal Supports is based on assessed need. The following criteria will be used for participants to access Personal Supports: 1. Participant needs support for community engagement (outside of meaningful day services) or home skills development; and 2. This service is necessary and appropriate to meet the participant's needs; 3. The service is the most cost-effective service to meet the participant's needs.
3. Cost Effectiveness a. Remove the "most cost-effective" requirement unless clearly defined, with exceptions for health and safety. b. Clarify that person-centered planning prevails over cost restrictions.	Not Accepted	The service must be the most cost-effective service to meet the participant's needs. All authorized services are based on goals and needs in the participant's Person-Centered Plan.
4. Service Authorization a. Allow concurrent services where medically or functionally necessary and require individual review, not blanket prohibitions.	Not accepted	Personal Supports 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 Home, Shared Living, Day Habilitation, Employment

		Services, Medical Day Care, Respite Care Services, Supported Living, or Transportation Services. Children have access to any medically necessary preventive, diagnostic, and treatment services under Early and Periodic Screening, Diagnostic, and Treatment services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this Waiver service are to improve and maintain the ability of the child to remain in and engage in community activities.
5. Virtual Supports a. Reframe policy to allow full virtual access to personal supports services upon person-centered team agreement. b. Include a waiver or exception clause for those with documented access needs, for personal supports to be entirely provided virtually.	Not Accepted	The level of support and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's level of service need. This Medicaid waiver program service may not be provided entirely via virtual supports. Personal Supports enhanced and overnight supports cannot be provided virtually.

Remote Support Services

Remote Support Services		
Comment	**Department Comment**	**Department Response**
1. Video and Audio Requirement a. Requiring virtual support staff to simultaneously see and	Clarification	Remote Support Services provide oversight and monitoring within the participant's home through an off-site electronic support system

hear participants at all times may infringe on participant rights. Individuals may wish to mute or turn off their camera for privacy, especially during sensitive tasks or health-related interactions. Additionally, for job coaching, participants often move about their worksite, making constant video contact impractical.		in order to reduce or replace the amount of staffing a participant needs, while ensuring the participant's health, safety, and welfare. As per the currently approved waiver, this service must be designed and implemented to: 1. Ensure the need for independence and privacy of the participants who receive services in their own home. 2. Provide the participant with the options to have control over the equipment, including the ability to turn off the remote monitoring device/equipment, if they choose to do so unless otherwise required as noted in a Behavioral Support Plan or Nursing Care Plan. Assistive Technology is used to support Employment Services.
2. Virtual Supports a. Remove proposed requirement for an unpaid caregiver to be physically present during virtual service delivery. b. Check "Remote via Telehealth" designation, as Remote Supports are inherently delivered virtually.	a. Clarification b. Accepted	a. There is not a requirement for an unpaid caregiver to be physically present during Remote Support Services. b. The option was added.
3. Employment Supports a. The employment/work environment should be added as an option to utilize remote supports. These are not supports that are specific to a person's home and would be beneficial for some folks when they are working.	Clarification	Remote Support Services provide 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, while ensuring the participant's health, safety, and welfare. The Medicaid waiver program also includes Assistive Technology Services. Assistive Technology means an item, computer application, piece of equipment, or product system. Assistive Technology may be used in the person's own home as well as in the community. Assistive Technology can be used to support Employment Services.

4. Combining Remote Supports and Assistive Technology Services a. Remote Supports and Assistive Technology Services should be collapsed into one service where a person can access whatever is needed instead of having to piece things together.	Not accepted	Remote Support Services and Assistive Technology are specific distinct services. Participants can assess both services based on assessed need. Remote Support Services provide 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, while ensuring the participant's health, safety, and welfare. Assistive Technology means an item, computer application, piece of equipment, or product system. Assistive Technology may be acquired commercially, modified, or customized.
5. Control a. Applauds the DDA's proposal to allow participants the option to have control over remote supports equipment, including the ability to turn off remote monitoring equipment at their discretion.	Accepted	The DDA appreciates this feedback.

Respite Care Services

Respite Care Services		
Comment	**Department Comment**	**Department Response**
1. Day trips a. Recommendation: Do not remove day trips from Respite Care Services. b. Remove "travel adventures (unless it is a day trip)" from J	a. Accepted with amendment	The proposals will be removed from the amendment for further discussions with stakeholders.

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on page 2	b. Not accepted with amendment	Respite is short-term care intended to provide both the family or other primary caregiver and the participant with a break from their daily routines. Respite does not pay for travel adventures.
2. Participants Under 18 Year Old a. Reaxamine the issue of removing the requirement for a staff member to be 18 years old, and re-examine this issue to gather stakeholder input from providers, people being supported, families.	Accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
3. Family Members Providing Services a. Allow extended family members, such as aunts and uncles, to provide up to 80 hours of respite overtime per fiscal year to give primary caregivers the opportunity to take a break. b. Treat family members who provide respite through a contract with a community provider the same as "individuals providing services for participants self-directing their services" and only require standards 1-6.	Not Accepted	Relatives can provide no more than 40-hours per week of services. Family members that provide respite through a contract with a community provider must meet all required qualifications.
4. Billing a. Respite staff should be compensated with a 24-hour wage when providing overnight care in their own home, as this arrangement mirrors overnight respite services in a facility, with similar accommodations b. Clarify where respite camp providers get their guidelines for what is a "reasonable and customary" fee.	a. Not Accepted b. Clarification	a. Respite Care Services are 15-minute services and can be billed up to 720 hours within each Person-Centered Plan year. b. The DDA will share additional information on reasonable and customary fees.

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5. Clarify if respite is a 1:1 service or if it can be provided in small groups	Clarification	Respite Care Services are a one to one direct service unless attending camp.
6. Pay Private Duty Nurse Residential Service Agency a. Allow Rare and Expensive Case Management participants to pay for an appropriate number of hours or dollar amount of respite care by using waiver funding to pay the same Private Duty Nurse Residential Service Agency that provides services to begin with.	Not Accepted	The Medicaid waiver program provides habilitative services and does not pay for private duty nursing.
7. Staff Qualifications a. Respite care professionals should be certified by the Maryland Board of Nursing (MBON) as medication technicians if they are unlicensed staff who administer medications or perform delegable nursing tasks.	Not Accepted	For a paid provider of Respite Care to administer medications or perform delegable nursing tasks, they must have been delegated by a Registered nurse.
8. Training Requirement a. Allow training flexibility for family members and friends who are selected by the person or their family/representative to provide respite care.	Clarification	Family members and friends working for or under a DDA provider contract must meet all training requirements. Employees of self-directed participants providing respite must minimally: ● Possess current First Aid and CPR certification or Emergency Medical Technician (EMT); ● Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2; ● Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing as Medication Technicians, except if the participant and their medication administration or nursing

		tasks qualifies for exemption from nursing delegation pursuant to Code of Maryland Regulations 10.27.11; • Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and • Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services. Participants can require additional training based on their preferences.
9. Agency Qualification Experience Requirement a. Delete the requirement that an agency have 5 years of respite experience in order to become licensed as a respite care provider, and adopt original language requiring 5 years of similar experience.	Accepted with amendment	The requirement was updated to reflect: A minimum of 5 years demonstrated experience and capacity providing quality respite care or personal care assistance services.
10. Approved Camps a. Add clear standards and criteria for what constitutes "approved" camps or settings to prevent arbitrary exclusions or approvals and ensure equity and due process.	Clarification	Camps must be State certified and licensed as a camp including overnight and youth camps as per Code of Maryland Regulations 10.16.06, unless otherwise approved by the DDA.
11. Day Care a. Remove the prohibition on using respite care during work hours. Clarify instead that respite is based on individualized need regardless of the caregiver's employment status.	Not Accepted	Respite cannot replace day care while the participant's parent or guardian is at work.
12. DDA approved providers a. Revise vague references to DDA "approval" with objective	Clarification	Providers must apply to become a DDA provider. DDA approves providers if they meet requirements. For more information on

criteria and clear timelines.		becoming an approved provider, visit the Partnering with Providers webpage.
13. CPR/First Aid a. Adopt remote or hybrid training options for CPR/First Aid to ensure accessibility, particularly for rural or disabled caregivers.	Not Accepted	At minimum, employees must participate in an in-person skills session that will require them to show that they are able to perform CPR and First Aid skills.

Shared Living

Shared Living		
Comment	**Department Comment**	**Department Response**
N/A		

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Support Broker Services

Support Broker Services		
Comment	**Department Comment**	**Department Response**
1. Service Requirements a. Remove proposed restrictions from Support Broker Responsibilities. b. The Support Broker should continue requirements to have CPR/First Aid training every two years. c. Allow relatives/legal guardians to serve in dual roles where supported by the person-centered plan d. Permit reimbursement for administrative tasks when they are essential to service delivery. e. Retain Support Broker as optional and participant-driven—mandate only when a conflict of interest is demonstrably shown.	a. Clarification b. - e. Not accepted	a. The service description was updated to simplify information in alignment with the Center for Medicare and Medicaid Services' Technical Guide. b. Support Brokers will not be required to have CPR/First Aid training. Participants, as the employer, can require these training. c. Dual roles present conflict of interest. d. The scope of services are noted within the Medicaid waiver. e. Support Broker Services are mandated by the Self-Directed Services Act of 2022.

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2. Support Broker Hours a. Remove proposal that Support Brokers can provide collectively for all participants they support up to 40 hours per week of Support Broker Services. b. Limit the hours worked, limit it by a monthly allotment (160 hours). c. Allow unlimited Support Broker hours when required to meet the participant's needs.	a. Accepted with amendment b. & c. Not accepted	a. The proposals for limiting Support Brokers to provide collectively for all participants they support up to 40 hours per week of Support Broker Services will be removed from the amendment for further discussions with stakeholders.
4. Non Disclosure Agreements a. Do not allow Support Brokers to have Non Disclosure Agreements.	Accepted	Support Broker will be added to the amendment to reflect: Non-disclosure agreements with participants associated with the Medicaid waiver program services are prohibited for all providers of services and supports including employees, vendors, DDA Medicaid Providers, Coordinators of Community Services, Support Brokers, and Financial Management and Counseling Services providers.
5. Overlap of Support Broker and Coordinator of Community Services functions: 1. Get rid of Support Broker Services, as the Coordinator of Community Services could provide these job functions. 2. Restrict Support Broker Functions that Overlap with Coordinator of Community Services Duties. "Support Broker Services may not replace any support which Coordinators of Community Services are authorized to provide." 3. Allow Support Brokers to provide supports with person-centered planning, problem-solving, advocacy, and coordinating services duties	Not Accepted	Support Broker Services are available to participants in the Self-Directed Services Delivery Model. Support Brokers and Coordinators of Community Services serve two distinct roles for a participant. Support Broker Services may not duplicate other Medicaid waiver services, including case management. Support Broker Services may not duplicate, replace, or supplant case management (Coordination of Community Service). The DDA will consider these recommendations for a future amendment, with stakeholder engagement.

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6. Prohibit Contact with Agencies Without the Participant a. Requirement that "Support Brokers shall never contact any team member or community partner... without the participant included, unless authorized…" is overly restrictive and may prevent brokers from performing essential functions, such as clarifying billing issues, scheduling meetings, or advocating on behalf of a participant with their consent. The standard should require documented consent or participant direction, not physical presence.	Clarification	Support Brokers may be authorized by the participant in the Participant Agreement to clarify billing issues, schedule meetings, or advocate for the participant. Support Brokers shall never bill for clarifying their own billing issues.
7. Conflict with Self-Direction Principles a. Maryland's Self-Direction Act of 2022 affirms that participants must have the right to choose and direct their staff, including Support Brokers. Policies that limit those choices through overly rigid restrictions, especially without individualized justification, may violate state law and federal person-centered planning standards (42 C.F.R. § 441.301).	Clarification	Participants have the right to choose and direct their staff, including Support Brokers.
8. Start Up Supports a. Allow Support Brokers to be paid for work provided prior to service delivery, beyond initial start up costs.	Not accepted	A participant must be enrolled and have an approved Person-Centered Plan before they can receive Medicaid services. The DDA cannot authorize services prior to approval of the Person-Centered Plan.
9. Supports Requested By Participant a. Add "as requested by the participant" to the phrasing, so it reads: "Support Brokers may provide support for reviewing time sheets and invoices if requested by the participant, but the participant always makes the decision"	Clarification	Support Brokers may only provide supports if requested by the participant.

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10. Non-Billable Activities a. Relevant correspondence and research approved by participants should be billable activities.	Not Accepted	Correspondence or research is a non-billable activity.
11. Virtual Supports a. Reinstate "Remote/telehealth" as a service delivery method for Support Broker Services	Not Accepted	The Center for Medicare and Medicaid Services added new data elements associated with telehealth/remote supports to the federal waiver application and technical guide. This includes a new check box associated with each service and a designated section within Appendix C -1 d. Remote/Telehealth Delivery of Waiver Services. Support Broker Services may be direct or indirect.
12. Core Competency a. The phrase "core competency" needs to be clarified to define the standards for which DDA will consider a Supports Broker "certified." Competency around the Americans with Disabilities Act (ADA) should be included within "core competency".	Clarification	A core competency focuses on developing essential skills and knowledge about the role of a Support Broker. The DDA will consider additional competencies such as the Americans with Disabilities Act with stakeholder engagement.
13. Training Requirements a. Retain "complete necessary/in-service training" based on person specific information (including preferences, positive behavior supports, when needed, and disability-specific information as noted in the person-centered plan and DDA required training for Support Broker training	Not accepted	Support Brokers must satisfactorily complete all required orientation and training designated by DDA including the Policy on Reportable Incidents and Investigations and Support Broker trainings, The participant may request additional training based on their needs.
14. Support Broker Volunteer Program a. Create a support broker volunteer program, whereby	Clarification	Individuals interested in providing Support Broker Services can complete the required training. The DDA developed a Self-Directed Services training series that is available for anyone, including

family members (and others) willing to serve as a support broker without compensation receive the needed assistance to help participants self-directing their services.		individuals that would like to provide services without reimbursement. An overview of Support Broker training is available here.
15. Training a. Streamline support broker certification with built-in due process and accessible timelines.	Clarification	Support Brokers must complete Support Broker Certification training in order to become certified to provide Support Broker services. An overview of Support Broker training is available here.

Supported Living

Supported Living		
Comment	**Department Comment**	**Department Response**
1. Dedicated hours a. Clarify the language that allows for people who are retired to have dedicated hours in their home to say that the staff can be shared or 1:1, depending on the needs identified in the person's plan.	Clarification	If the participant needs dedicated support hours due to medical or behavioral support needs, daytime support needs, or increased community integration needs, then a request for dedicated staff hours may be submitted as per guidance and policy.
2. Authorization of services for minors a. Recommendation: On page 2, item A, reinstate the language allowing DDA the ability to authorize services for someone under the age of 18.	Not Accepted	Supported Living Services are not available to participants under the age of 18.

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3. Awake and Alert Overnight a. Remove the awake overnight requirement. Comments included but not limited to: • Differentiate between "Awake" overnight 1:1 staffing and overnight supervision by staff available for emergencies and any issues that may arise recognizing that most individuals need staff 'available' • Having staff present, but not necessarily awake, models sleep appropriateness, reduces chaos in the group home, reduces the need for sleep medications, reduces stimulation, requires less staff with the current Direct Support Professional (DSP) staffing shortage, and provides safety for individuals by having staff present. It also promotes a home-like environment compared to an institution • Some people may need staff "on site and on call," not all people need their staff to be awake while onsite, to be healthy and safe • Requiring all staff to be awake does not take into account the person-centered needs of the individual, or the change in energy and dynamic that an awake overnight situation may incite, which may be considerably more institutional-restrictive and disruptive in nature than what may be required for the health and safety of a person receiving waiver services • Allow services to continue as-is, around the clock for those who need monitoring and supervision, but creating a separate service of Awake Overnight that allows for an overnight pay differential to hire the appropriate staff. Legal guardians/relatives should not be eligible to work	Accepted with amendment	Based on stakeholder feedback, the requirement for overnight supports to be awake and alert has been removed, for further discussions with stakeholders related to overnight supports. Note: Participants with a Nursing Care Plan or Behavior Support Plan that required awake overnight staff must be provided by awake and alert staff as per the Nursing Care Plan or Behavior Support Plan.

awake overnight • If a person needs some supervision support overnight, but not necessarily Awake and Alert, they will have no option for overnight supports		

Transition Services

Transition Services		
Comment	**Department Comment**	**Department Response**
1. Access to services a. Based on assessed need and the determination of the team, money should be available to anyone moving .	Not accepted	Transition Services provides certain funding for allowable expenses related to the participant moving from: (1) an institutional setting to a group home or private residence in the community for which the participant or their legal representative will be responsible; or (2) a community residential provider to a private residence in the community, for which the participant or their legal representative will be responsible.
2. $5,00 lifetime cap a. Remove arbitrary $5,000 lifetime cap or replace with a flexible needs-based ceiling tied to housing costs.	Not accepted	The maximum payment for this service may not exceed $5,000 per participant during their lifetime.
3. Ownership a. Eliminate the item return requirement and confirm participant ownership post-purchase.	Clarification	The participant has ownership over all items purchased if they choose. If they no longer want any item purchased under this service, the item shall be returned to the DDA.

4. Purchases from Relatives/Vendors a. Allow purchases from relatives/vendors where safeguards and conflict-free protocols are met.	Not accepted	This service cannot pay for purchase of items and goods from the participant's relative, legal guardian, or legally responsible person.
5. Regulations a. Codify participant-directed procurement mechanisms within the Self Directed Services model.	Accepted with amendment	The Department will issue regulations associated with all services, standards, and requirements for the Medicaid waiver program.

Transportation Services

Transportation Services		
Comment	**Department Comment**	**Department Response**
1. Day Trips a. Do not remove day trips from Transportation	Accepted with amendment	The proposals to remove day trips as a service under the stand alone Transportation Service will be removed from the amendment for further discussions with stakeholders.
2. Community Definition a. Expand the definition of "community" to encompass the entire state rather than limiting it to an individual's immediate geographic area. This broader definition would increase opportunities for participants to engage, connect, and access services beyond their local area, fostering greater inclusion.	Not accepted	For the stand alone Transportation Services, community is defined as: places the participant lives, works, shops, or regularly spends their days.

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3. Transportation for Medical Needs a. Recommend allowing transportation to and from doctor's offices and other medical appointments to be a reimbursable expenditure for staff mileage.	Not Accepted	In Maryland, Medical Assistance Non-Emergency Medical Transportation (NEMT) is available for recipients who have no other means of getting to their medical appointments. Transportation services are provided by the local jurisdictions. To obtain transportation, please refer to the Local Transportation Contacts For additional information please see the dedicated website at: https://health.maryland.gov/mmcp/communitysupport/Pages/Home.aspx
4. Requirements for Uber and Lyft a. Remove the requirement that "anyone paid to provide a Medicaid waiver service..are considered a Medicaid provider" for commercial providers like Uber and Lyft	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
5. $7,500 Limit a. Permit exceptions to $7,500 cap for individuals with higher needs based on person-centered planning	Not Accepted	Transportation is limited to $7,500 per year per participant.
6. Regulation a. Codify a legally responsible persons waiver process to allow timely approval where no alternatives exist.	Accepted with amendment	The Department will issue regulations associated with all services, standards, and requirements for the Medicaid waiver program.
7. Other Funding Sources a. Create an expedited, non-burdensome process for verifying other funding source exhaustion.	Clarification	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and appropriate funding sources must be explored and exhausted to the extent applicable. Prior to accessing DDA funding for this service, all other available and appropriate funding sources which may include, as applicable, private

		insurance, services offered by Maryland Medicaid State Plan, Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), Department of Human Services (DHS), and any other federal or State government funding program, must be explored and exhausted to the extent applicable. The Coordinator of Community Services can assist in identifying other sources of funding.
8. Remote Tools a. Allow the use of remote tools for travel training and transport coordination when appropriate.	Not Accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
9. Service Overlap a. Revise service overlap rules to allow transportation for appointments not part of other waiver services.	Clarification	Transportation Services are designed specifically to improve the participant's and the family caregiver's ability to independently access community activities within their own community in response to needs identified through the participant's file.

Vehicle Modifications

Vehicle Modifications		
Comment	**Department Comment**	**Department Response**
1. Training for Coordinators of Community Services a. Provide training for Coordinators of Community Services on implementing access to vehicle modifications. Improve collaboration between DDA, individuals, and providers to	Clarification	DDA provides ongoing training opportunities to Coordinators of Community Services. The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

ensure no services proceed without proper approval, avoiding financial risk.		
2. Limits on the amount, frequency, or duration of Vehicle Modifications a. Allow funding above $15,000 based on actual service delivery, medical or functional necessity and receipts b. Add flexibility to the 10-year ability to make the request again	Not accepted	Vehicle Modifications payment rates for services must be customary and reasonable according to current market values, and may not exceed a total of $15,000 within 10 calendar years The Department appreciates this feedback, and will have further engagement with stakeholders to identify future changes to waiver services.
3. Private-Party Vehicle Purchases a. Permit Private-Party Vehicle Purchases - explicitly permit purchases of wheelchair-accessible vehicles from private-party sellers, provided they meet basic functional and safety criteria.	Not accepted	Vehicle Modifications do not include the purchase of new or used vehicles.
4. Leased Vehicles a. Permit modifications on leased vehicles or those used daily by participants with valid justification.	Not accepted	Modifications are for vehicles owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other caretaker as approved by the DDA. The Medicaid program does not provide assistance with modifications on vehicles not registered under the participant or legally responsible parent of a minor or other primary caretaker. This includes leased vehicles.
5. Legally Responsible Persons a. Create a hardship or legally responsible persons exemption path under controlled circumstances.	Not accepted	A legally responsible person, relative, or legal guardian of the participant cannot be paid by the Medicaid waiver program, either directly or indirectly, to provide this Medicaid waiver program service.

6. Emergency Repair Provision a. Develop an emergency repair provision for accident-damaged modifications critical to participant safety.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement. Note: An emergency revised plan can be created to request Vehicle Modifications in this type of situation.
7. Other Funding Sources a. Clarify procedures for funding source exhaustion with standardized timelines and appeal rights.	Clarification	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and appropriate funding sources must be explored and exhausted to the extent applicable. Prior to accessing DDA funding for this service, all other available and appropriate funding sources which may include, as applicable, private insurance, services offered by Maryland Medicaid State Plan, Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), Department of Human Services (DHS), and any other federal or State government funding program, must be explored and exhausted to the extent applicable.

Appendix D - Participant-Centered Planning and Service

Appendix D - Participant-Centered Planning and Service		
Comment	**Department Comment**	**Department Response**
1. Staff Training a. While the changes in Appendices D and E are excellent, the DDA should ensure there are enough skilled and fully trained staff to effectively implement and support these	Clarification	DDA appreciates this feedback and continuously provides training for staff. Thank you for this recommendation.

amendments. b. Consider Level of Care training for Coordinators of Community Services. c. Clarify which laws apply to participant-directed workers		
2. In-home monitoring a. Do not allow Coordinators of Community Services to do in-home monitoring visits for participants in Self-Directed Services. b. Define standards for compliance during monitoring.	Not Accepted	In-home monitoring visits are required to ensure health and safety of the participant, and to make sure that they are getting the services they need. The DDA will update the DDA CCS Monitoring and Follow-Up Guidance.
3. Mandatory Self-Directed Services Training a. Do not require mandatory training for participants prior to transitioning into self-directed services. The proposed amendment contains no details or standards for how the Department intends to assess or certify the participant's understanding or decision. This process risks becoming a de facto competency test, one that will radically alter who may self direct their services.	Not Accepted	A mandatory DDA self-directed orientation/training is required for all new applicants and participants using the Provider Managed Service Delivery Model interested in the self-directed service delivery model. The training is to: a. Support the applicant/participant to fully understand their rights, role and responsibilities under the self-directed service delivery model; and b. To ensure an informed decision prior to enrollment into the Self-Directed Service Delivery Model. The mandatory orientation/training is not a competency test.
4. Supported Decision Making a. Facilitate a webinar that is available at multiple times with Disability Rights Maryland to ensure that families understand Supported Decision Making.	Accepted	The DDA will partner with Supported Decision Making subject matter experts to offer a webinar. There are various resources related to Supported Decision Making including but not limited to: ● Disability Rights Maryland - https://tinyurl.com/236jh46j

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		• The Parents' Place of Maryland - https://tinyurl.com/6b345axp
5. Role of Coordinators of Community Services a. Require Coordinators of Community Services to provide unbiased, balanced information to people about the services available, benefits, opportunities, and responsibilities in both service models b. Emphasize the essential role of case managers advocating for the people they serve, while maintaining a conflict-free approach	Clarification	Coordinators of Community Services are required to provide options about both the Provider Managed model and the Self-Directed Service Delivery model. Coordinators of Community Services role is clarified in the waiver amendment.
6. Service Model Transitions a. Insert transition timelines and accommodations for providers currently in good standing under self-directed services.	Clarification	Service model transitions will vary to ensure no description in service delivery. Transitions are also based on the participant's choice and hiring of employees, vendors, and providers.
7. Independent Appeals Or Grievance Procedure a. Implement an independent appeals or grievance procedure for participants facing adverse actions. b. Require notice and appeal opportunities prior to any adverse action. c. Protect participants from loss of services based on provider or Financial Management and Counseling Services administrative delays or errors.	Clarifications	The Maryland Department of Health's Office of Health Care Quality (OHCQ) handles complaints related to the quality of care in Maryland community-based programs. You can file a complaint online by completing an online complaint form. If it is not possible for you to submit a complaint on-line, you may mail or fax the Paper Complaint Form. Notice and appeal requirements are noted within Appendix F. Service providers must meet service requirements and standards.
8. Performance Metrics a. Integrate participant voice and person-centered	Clarification	The DDA also uses the National Core Indicators (NCI)™, which is a voluntary effort by public developmental disabilities agencies to measure and track performance. These National Core Indicators

outcomes into performance metrics.		are standard measures used across states to assess the outcomes of services provided to individuals and families. They address key areas of concern related to participants including employment, rights, service planning, community inclusion, choice, and health and safety. Appendix D includes two measures specific to the National Core Indicators
Person-Centered Plan Changes a. All plan changes should require participant consultation and offer recourse through fair hearings	Clarification	The participant's Person-Centered Plan signature page includes the attestation that the person certifies the following: ● I participated in making this plan. ● I agree with the contents of the plan, including its documentation of my needs, goals and the service being requested for approval by the DDA. ● I understand that I am free to: ○ Choose my person-centered planning team; ○ Choose from any qualified provider for my services; ○ Choose the service delivery method of either Self-Directed Services or Traditional Services; and ○ Request a modification of my plan based on if my needs change. ● I have received information and understand how to identify and report potential abuse, neglect, and exploitation. Medicaid fair hearing information is noted within Appendix F.

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Appendix E - Participant Direction of Services

Appendix E - Participant Direction of Services		
Comment	**Department Comment**	**Department Response**
1. Changes to Self Directed Services Policy and Practice a. The DDA should solicit public comment before implementing updates to the Self-Directed Services policy and manual. The state should not create any new rules or requirements that affect waiver services unless they are: ● Written clearly in the waiver document. ● Included in materials given to participants (like handbooks or guides). ● Shared with the public for review and comment before being put into action.	Clarification	DDA will continue to engage stakeholders throughout the process of waiver, policy, and manual development.
2. Self-Directed Services a. Any service that can be safely and effectively provided under the self-directed services module should be available in the model.	Not accepted	Most services are available under the Self-Directed Services. Services available under the self-directed model are reflected in Appendix C and E.
3. Financial Management and Counseling Services Providers a. All participants should have a choice multiple Financial Management and Counseling Services providers	Clarification	Participants have a choice of three Financial Management and Counseling Services providers.
4. Self-Directed Services Orientation and Training a. Clarify the nature and population that must have the	a. Clarification	a. A mandatory DDA self-directed orientation/training is required for all new applicants interested in self-directing their services and participants using the Provider Managed Service Delivery Model

newly-proposed training on the self-direction model, and ensure that any training materials are balanced in their representation of the provider model vs. the self-directed model. b. Make training available for Coordinators of Community Services c. Participants already enrolled in Self-Directed Services should be excluded from the mandatory training. d. Remove training requirements altogether, as support brokers already provide necessary guidance, and the training may create unnecessary delays. e. Require two semi-annual trainings for all Direct Support Staff in the Self-Directed Services program, to ensure ongoing skill development and program consistency	b. Clarification c. Clarification d. Not accepted e. Not accepted	interested in the self-directed service delivery model. The training is to: • Support the applicant/participant to fully understand their rights, role and responsibilities under the self-directed service delivery model; and • To ensure an informed decision prior to enrollment into the Self-Directed Service Delivery Model. The mandatory self-directed orientation/training is required for new participants entering the Self-Directed Service Delivery model. Current participants self-directing are encouraged to take the training and not required to take the training. Individuals enrolled in the waiver with an effective date of October 6, 2025 through December 31, 2025, must complete the mandatory training by or before March 31, 2026 if not already completed. If not completed by March 31, 2026, the participant will be transitioned to the Provider-Managed Service Delivery Model. b. The Self-Directed Services Training Series is available for anyone, including participants, family members, Support Brokers, Coordinators of Community Services, Financial Management and Counseling Services providers, and all service providers, vendors, and employees. The DDA will be developing additional modules specific to Coordinators of Community Services roles. e. Direct Support Staff are required to receive training in accordance with DDA policy and the DDA training matrix. Additionally, various training opportunities are offered throughout the year by DDA.

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5. Self-Directed Service Opportunity a. Do not allow the Self-Directed Service option for participants who need total care, as this does not fit the services definition of Self-Directed Service.	Not accepted	A participant may choose either the provider managed model or the Self-Directed Services model, based on their individual needs and goals.
6. Involuntary Termination of Participant Direction a. Ensure participants in the Self-Directed Services model are not removed for unclear reasons. b. Clarify the word "overutilization", including transparent guidelines to follow the removal from services. c. Remove overutilization as a reason for termination. d. Change statement that DDA "may first, at its sole discretion" to "DDA shall..." to ensure a person has the opportunity to explain or appeal to DDA. e. Provide timelines and steps for reinstatement.	a. Clarified b. Clarified c. Not Accepted d. & e. Not accepted	a. The DDA clarified the reasons under which a participant in Self-Directed Services may be terminated from the model. b. Overutilization of authorized services is when a authorizes an employee or provider to provide services when they have already used all authorized services in their Person-Centered Plan. c. DDA maintains that overutilization of services is a reason for termination. In instances where a participant overutilizes authorized services, before involuntarily terminating the participant from the self-directed services model, DDA may first, in its sole discretion: 1. Require the participant to meet with DDA and their team to review rights and responsibilities including the monitoring and usage of funding for authorized services; and/or 2. Require a corrective action plan from the participant. d. & e. The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
7. Code of Conduct a. All service providers or direct support staff should be required to sign a code of conduct. A universal provider code of conduct would help ensure quality and respect for participant rights across all services, and if not, what alternative mechanisms ensure providers in every service follow principles that protect the participant's dignity and	Clarification	To be approved as a service provider, agencies must have policies and procedures in place which include, how participants' health and safety are being met, how participants' rights are ensured, that services are provided in a manner that promotes individual choice and exercise of individual rights, confidentiality practices, implementation of a grievance process, and how services are provided without discrimination.

choices?		The DDA will consider this recommendation for a future amendment, with stakeholder engagement.
8. Self-Directed Services Budget Flexibilities a. Allow participants who self-direct their services to make changes to their budget without a Revised Person-Centered Plan. b. Give appeal rights to participants who submit a budget modification that is denied. c. Participants should be able to change their services at any time within their approved budget.	Clarification	The DDA allows a budget modification process that allows participants who self-direct to change their budget without completing a Revised Person-Centered Plan. Budget modifications must meet the listed standard. A participant has the right to appeal a budget modification that is denied. Participants may do a revised PCP as their needs change.

Appendix F - Participant Rights

Appendix F - Participant Rights		
Comment	**Department Comment**	**Department Response**
1. Case Resolution Conference Comments include but not limited to: a. Retain the Case Resolution Conference for Person-Centered Plans. b. Restore the option for a person to request a Case Resolution Conference for any purpose you could also request a Medicaid Fair Hearing to resolve. c. If DDA moves entirely to the Fair Hearing route for grievances, it is crucial that participants be informed and supported in exercising their appeal rights. d. Reinstate an informal dispute resolution step for service denials and improve guidance on appeals.	Not accepted	The Maryland Department of Health informs the individual and their family or their legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA or the Maryland Department of Health. The Maryland Department of Health provides a written letter notifying the individual of its adverse decision including Notice: Medicaid Fair Hearing Rights. The Maryland Department of Health Medicaid office has "Request a Fair Hearing. File an Appeal." website that includes information related to:

e. DDA should maintain an accessible internal dispute resolution mechanism for service denials – whether it's reinstating the Case Resolution Conference or another expedited review. f. Require disclosure that CRC is optional and does not limit appeal rights. i. Allow participants to request third-party mediators not employed by DDA. ii. Guarantee access to free legal counsel or advocate prior to participating in CRC.		• Your Fair Hearing Rights • Notice of Hearing Date and Location • Before the Hearing • During the Hearing • Hearing Decisions • Frequently Asked Questions • How do I request a fair hearing • The option to submit a fair hearing request online for anyone applying for or enrolled in Medicaid who thinks a decision to deny, suspend, end, or reduce their Medicaid eligibility or services is wrong has the right to ask for a fair hearing about that decision; and • Ability to submit a Request for Fair Hearing via mobile request form. The website can be viewed at https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx.
2. Appeal Process a. Include a fair, well-defined appeals process to protect participants' rights and service continuity. b. Clarify if a Coordinator of Community Services can submit an appeal on behalf of the person supported at the participant's request. c. Require MDH/DDA to proactively offer alternate formats upon initial denial. d. Expand the CCS role to mandate third-party legal referral (e.g., Maryland Legal Aid or DD-specific advocacy groups). e. Add appeal rights and procedural protections when DDA denies service approvals or requires exhausting other programs. f. Restore participant autonomy by aligning with the Centers for Medicare and Medicaid Services'	a. & b. Clarification c. Not accepted d. Not accepted e. Clarification f. Clarification	a. Appendix F includes: The Maryland Department of Health has a dedicated website - "Request a Fair Hearing. File an Appeal" that includes language information related to: 1. Your Fair Hearing Rights; 2. Notice of Hearing Date and Location; 3. Before the Hearing; 4. During the Hearing; 5. Hearing Decision; 6. Frequently Asked Questions; 7. The option to submit a fair hearing request online for anyone applying for or enrolled in Medicaid who thinks a decision to deny, suspend, end, or reduce their Medicaid eligibility or services is wrong has the right to ask for a fair hearing about that decision; and

requirements for choice, control, and individualized service planning.		8. Ability to submit a Request for Fair Hearing via mobile request form. The website can be viewed at https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx. b. Coordinators of Community Services can support a person filing an appeal. c. & d. The DDA will consider this recommendation for a future amendment, with stakeholder engagement. e . Appeal rights are noted in Appendix F. f. Participants have choice, control, and individualized service planning within the Medicaid rules.
3. Request a Fair Hearing b. Add to this statement that "individuals have the right to continue to receive services pending the appeal, ...and providers will be paid for the services provided through the appeal process." c. In cases where appeals are necessary, the DDA should ensure no services are cut off while an appeal is pending (to prevent gaps in care) and perhaps designate ombudsmen or advocates to assist individuals through the process.	Not Accepted	Participants' rights to a fair hearing are established under Medicaid, and not DDA.
4. Complaint and Grievance Process a. Establish a waiver-specific grievance procedure accessible via web, phone, and in person. b. Include protections for complaints involving provider abuse, CCS conflicts of interest, retaliation, or FMCS	Clarification	The Maryland Department of Health's Office of Health Care Quality (OHCQ) handles complaints related to the quality of care in Maryland community-based programs. You can file a complaint online by completing an online complaint form. If it is not possible for you to submit a complaint on-line, you may mail or fax the Paper Complaint Form.

barriers.		

Appendix G - Participant Safeguards

Appendix G - Participant Safeguards		
Comment	**Department Comment**	**Department Response**
1. Behavioral Support Plan Consent Revoked a. Uphold that a person has the right to withdraw consent at any time, and add that a provider has a right to proceed with discharge/transition from their organization if they have determined they can no longer safely support the person declining treatment. In all cases the safety and stability of the individual must be prioritized. b. Add the following language: " If the person and their legally authorized representative (as applicable) revokes consent for their Behavioral Support Plan, and the provider no longer feels that they can support the person safely without a Behavioral Support Plan, DDA shall immediately take action, in collaboration with the person and their team, to assist the person in finding an alternative provider or service option.	Clarification	If a provider does not feel like they can safely support a person under any circumstances that can work with the participant, their Person-Centered Planning Team, including the Coordinator of Community Services to find an alternative placement. The DDA Regional Office is also available to support the team.
2. On-Site Visits - Self-Directed Service Model a. Do not allow Regional Office staff or the Office of Health Care Quality staff conduct on-site visits in the home for participants in Self-Directed Services.	Not Accepted	Medicaid waiver programs include safeguards to support the health and welfare of participants. DDA staff conduct on-site interviews with participants and the DDA provider's staff during visits and ascertain services are delivered in accordance with plans and that the participant is satisfied with the services being received.

		To ensure the health and safety of participants the Office of Health Care Quality can investigate any incident or complaint that happens at DDA providers or during the delivery of funded services including self-directed services. This is defined further in the Policy on Reportable Incidents and Investigations (PORRI).
3. Safeguards, Oversight Practices, or Investigative Protocols a. This amendment should outline safeguards, oversight practices, or investigative protocols DDA uses when reports are made of theft, sexual harassment, physical abuse, financial exploitation, or unethical conduct by agency staff. b. Require due process protections for participants before enforcement action. c. Require that corrective actions follow a notice, explanation, and hearing opportunity. d. Provide written guidance to participants about their rights when incidents are logged. e. Reinforce safeguards through quality assurance and incident reporting—not categorical exclusions. f. Define incident categories more precisely.	Clarification	A Medicaid waiver program's design must provide for continuously and effectively assuring the health and welfare of waiver participants, pursuant to 42 Code of Federal Regulations § 441.302(a). This includes: • Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications • Monitoring the implementation of the service plan and participant health and welfare • Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants • Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights All Medicaid providers must complete this requirement for all of the provider's employees and contractors hired to provide direct care, whether in the provider managed or self-directed service delivery system prior to service delivery. A child protective clearance is also required for staff working with participants under the age of 18. The Policy on Reportable Incidents and Investigations (PORRI) and Investigations requires that all providers (employees, vendors, and DDA providers) report critical events or incidents to the DDA.

		The Policy on Reportable Incidents and Investigations is incorporated into the DDA's regulations governing requirements for licensure for providers. If there is a critical event or incident the provider, who is providing services at the time of the incident, must report the event or incident to DDA. Either the DDA or the Office of Health Care Quality reviews each reported event or incident, depending on the classification. The Office of Health Care Quality is the DDA's designee within the Maryland Department of Health, who is responsible for conducting surveys and investigative activities to monitor regulatory compliance, on the DDA's behalf, about provider licensure. The Policy on Reportable Incidents and Investigations also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), Adult Protective Services (APS) or Child Protective Services (CSP) (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., Maryland Board of Nursing). Participants are provided written notices regarding their right to appeal and due process.
4. Audit Services including Legally Responsible Persons a. Require providers to be subject to randomly selected, statistically valid samples of services provided, in addition to legally responsible persons.	Clarification	The Quality Improvement Organization conducts quality review including community provider-managed providers and self-directed services. The reviews include when Legally Responsible Persons are caregivers. For more information please visit the DDA Compliance and Quality Improvement website at: https://health.maryland.gov/dda/Pages/Compliance-Quality-Improvement.aspx
5. Critical Incident Reporting for Self-Directed Services	Accepted	The Department appreciates this feedback.

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a. Strongly support the addition that all providers under the Self-Directed Services and Provider Managed Services Delivery models to report critical events or incidents to the DDA		
6. Wellness Checks a. Define or clarify the meaning of "wellness checks"included in the waiver language under page 31	Clarification	The Coordinator of Community Services conducts quarterly wellness checks to ensure the health and safety of the participant, and to make sure they are receiving services based on their needs, as outlined in the Person-Centered Plan.
7. Consent a. Require written participant consent and allow participants to propose alternatives	Clarification	Participants must provide consent on service provisions including but not limited to the Person-Centered Plan, Behavior Support Plan and Nursing Care Plan.
8. Risk Mitigation Plans a. Integrate Risk Mitigation Plans into the existing person-centered planning process.	Clarification	Risk mitigation plans are incorporated into the Person-Centered Plan.

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Appendix H - Quality Improvement Strategy

Appendix H - Quality Improvement Strategy		
Comment	**Department Comment**	**Department Response**
1. Oversight - Quality Improvement Organization a. Agree with enhanced oversight by the Quality Improvement Organization and DDA to ensure participants are receiving the services and supports they need, and are free from abuse and neglect. b. Include specific oversight by the Quality Improvement Organization of self-directed services, including a plan to address and mitigate any conflicts of interest that may arise in the provision of those services. c. Define stakeholder roles more clearly and embed appeal procedures for participants. d. Introduce independent evaluation components (e.g., third-party audits). e. Mandate inclusion of participants' experiences with FMCS and CCS services, which are central to SDS.	a. Accepted b. Clarification c. Clarification d. Clarification e. Clarification	a. The Department appreciates this feedback. b. The Quality Improvement Organization will conduct service reviews for self-directed services. c. Appeal procedures are noted within Appendix F. d. The Quality Improvement Organization conducts independent service reviews. DDA-licensed/certified providers are also required to have independent financial audits. e. Participant experience surveys are completed by these providers.
2. Future Planning a. DDA should prioritize future planning for aging participants and their families, integrating it into Compliance and Quality Improvement initiatives. b. The DDA should partner with Coordinators of Community Services contractors to enhance future planning efforts by providing meaningful, supportive guidance to families	Accepted with amendment	The Department appreciates this feedback, and will have further engagement with stakeholders.

beyond simply advising them to "expand their circle of support"recognizing that many families have limited networks and varying levels of participation.		
3. Quality Improvement Organization Findings a. Allow findings from the Quality Improvement Organization (QIO) to be openly reviewed by DDA participants and increase DDA's response time for acknowledging participants' outreach and addressing their concerns. b. Require performance-based corrective action plans where systemic flaws are identified. c. Publicly report quality data stratified by relevant demographics to ensure equity compliance. d. Establish timeline and transparency for reporting survey outcomes. e. Codify a process for incorporating survey feedback into individual and systemic changes.	Clarification	The Quality Improvement Organization conducts various quality reviews and surveys. Quality Improvement Organization findings are shared with the provider and if assurances are not met, a corrective action plan may be required. The Quality Improvement Organization also conducts Personal Outcome Measures® (POM) interviews with participants. The Personal Outcome Measures is a person-centered discovery tool to explore the presence, importance, and achievement of personally-defined outcomes, along with the supports that help people attain their individual goals and dreams. A *Personal Outcome Measure flyer* can be found on DDA's website describing what to expect during the conversation and how the information you share is used: https://health.maryland.gov/dda/Pages/Quality-Improvement-Organization.aspx The DDA also uses the National Core Indicators (NCI)™, which is a voluntary effort by public developmental disabilities agencies to measure and track performance. These National Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. They address key areas of concern related to participants including employment, rights, service planning, community inclusion, choice, and health and safety. The Quality Improvement Organization (QIO) provides a report summarizing responses from National Core Indicators Participant surveys. This report is available annually on DDA's website by clicking on the Participant Survey at a Glance link: https://health.maryland.gov/dda/Pages/NCISurveys.aspx DDA shares this information through constant contact communications. DDA also invites Quality Improvement

		Organization to present the information during stakeholder meetings. The Quality Improvement Organization presents information regarding system trends at DDA Community Webinars, Regional Office Provider Meetings, and Coordinator of Community Services Meetings. The Quality Improvement Organization will also be sharing information at the Waiver Advisory Council Meetings. The Waiver Advisory Council provides input on: ● DDA-operated Medicaid waiver program system design; ● Service delivery and access to services; ● Federal waiver assurances; ● Ensuring Access to Medicaid Services (Access Rule); and ● Quality enhancement efforts and improvement strategies. The Quality Improvement Organization is exploring additional data summaries including statewide trends and quality improvement recommendations with significant impact on participants can be added to DDA's website. A scorecard is being developed by the Quality Improvement Organization to provide additional information on participants outcomes related to the following categories: ● Human Security ● Relationships ● Community ● Choices ● Goals The scorecard will also summarize participant experiences related to the following categories: ● Access to services ● Service delivery ● Case management

		• Community inclusion • Employment • Self-direction The DDA will have further engagement with stakeholders to identify additional ways to share information with participants and families.
4. Council on Quality and Leadership a. DDA should make public information on who the Council on Quality and Leadership is, how it is established and monitored to ensure the utmost fairness and transparency. Further, any grievances regarding the Council's decision making and its response should be made public and accessible online	Clarification	The Council on Quality and Leadership is an independent national entity that works with human service organizations and systems to continuously define, measure, and improve quality of life and quality of services for youth, adults, and older adults with intellectual and developmental disabilities, and psychiatric disabilities. Information on the Council on Quality and Leadership can be found at the DDA website, Liberty Health Care Corporation webpage.

Appendix I - Financial Integrity and Accountability

Appendix I - Financial Integrity and Accountability		
Comment	**Department Comment**	**Department Response**
1. Reduction of Funding in Certain Regions: a. The Maryland FY2026 budget required rate reductions in high-cost counties (the "Geographical Differential" areas). As a result, participants in Calvert, Charles, Frederick, Montgomery, and Prince George's counties will have lower service reimbursement rates and effectively reduced budgets for supports. This cutback, intended as	Clarification	The FY2026 Budget Bill preserved $37,690,000 for the purpose of funding a geographical differential rate paid for services in local jurisdictions where a geographical differential rate was paid in fiscal 2025. It further provided that DDA shall set the geographical differential rate for each service that is more than 10% above standard rates set for the rest of the State as of January 1, 2025, to no more than 10% above the standard rates set for the rest of the

a cost-saving measure, directly limits services that individuals in those communities can access. It is inequitable that a person's county of residence now affects the level of support they can afford. Lowering rates in higher-cost areas may also deter quality staff (who can find better pay elsewhere), further limiting participants' options. Any regional rate adjustments should be approached cautiously and paired with mitigation strategies (e.g. state supplement funding) so that participants do not lose services or staff availability due to their zip code.		State. DDA shall not eliminate the geographical differential rates of up to 10%. The Waiver was amended to allow the DDA to cap the geographical differential at 10% above the standard rates set for the rest of State for Calvert, Charles, Frederick, Montgomery, and Prince George's counties
2. Maryland Office of Legislative Audits a. Provide further clarification regarding which state agency will be audited every 3 years by the Maryland Office of Legislative Audits (OLA).	Clarification	All state agencies are subject to audit by the Maryland Office of Legislative Audits (OLA).
3. Quality Improvement Organization's Audit Frequency a. Clarifying whether the proposed change modifies the Quality Improvement Organization's audit frequency for traditional provider-managed services from quarterly to annually. If transitioning to annual audits, DDA should specify: ● The statistical sampling methodology ● The anticipated audit timeline and ● How service quality and compliance will be maintained under the new schedule	Clarification	The Quality Improvement Organization provides quality enhancement activities on behalf of the DDA. This includes measuring performance measures. You can find more information, including standard operating procedures on the DDA Liberty Healthcare Corporation webpage.
4. Cost-of-Living Adjustment a. Remove this statement on page 19 as this did not pass the Maryland Legislature: "A 1% Cost-of-Living	Accepted	The language was removed.

Adjustment has been proposed for FY2026 but must be approved by the Maryland Legislature"		
5. Financial Management and Counseling Service Help Desk a. Financial Management and Counseling Service providers should develop more dynamic ticketing tracking systems for budget modifications, vendor payment requests and other requests for help from FMS staff that take into account the urgency /priority of the request or the ability to resolve the request quickly b. Financial Management and Counseling Service providers should track and show vendor payment requests and budget modifications that have been waiting for 30, 60, 90, 120 and more days and provide this information to the DDA, Coordinator of Community Service staff (and participants if their request is on one of these lists) c. Financial Management and Counseling Service providers should set a standard expectation that the Financial Management and Counseling Services provider respond "within 2 business days." d. Financial Management and Counseling Service providers should be required to report to the DDA a monthly total of any vendor payment requests they have not paid because the vendor payment request was not resolved and paid timely by the Financial Management and Counseling Services and the participant/vendor or family member was forced to absorb the cost. e. The DDA should strengthen oversight and accountability mechanisms for Financial Management and Counseling Services agencies including:	Clarification	DDA contracts with Financial Management and Counseling Services agencies ensuring oversight and accountability. Financial Management and Counseling Services agencies must meet contract requirements for timely customer service responses. They may make decisions about establishing their own business practices related to ticketing systems, and invoicing and payment practices based on their business model. The participant may choose the Financial Management and Counseling Services agency that best meets their needs. Appeal processes are reflected in Appendix F.

• Enforcement of payment timelines. • Transparent reporting of service failures and clear processes for recourse when payments are missed. • Administrative fees should not be deducted from a participant's budgets without informed consent and demonstrated service performance. These measures are essential to maintain the integrity and stability of the Self-Directed model. f. Clearly define FMCS responsibilities as administrative—not discretionary—unless expressly authorized by state statute. g. Provide participants with appeal and exception request pathways.		
6. Audits and Notices a. Require clear audit dispute procedures. b. Include participant and guardian notice requirements and timelines. c. Clarify that overpayment liability should not fall on individual participants without willful misconduct. d. The state should provide a public explanation of methodology and assumptions. e. Allow stakeholders to comment on how these cost models affect participant budgets and access.	Not accepted	The DDA will consider these recommendations for a future amendment, with stakeholder engagement.

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Appendix J- Cost Neutrality Demonstration

Appendix J - Cost Neutrality Demonstration		
Comment	**Department Comment**	**Department Response**
1. Cost Neutrality a. Provide more transparency on the statistics being used to calculate institutional costs, along with the methodology DDA uses to determine trends for waiver years 4-5 b. Re-examine methodology that Hilltop Institute used for calculating institutional care to ensure the total care cost, for a person who resides in and spends the majority of their time in an institution, is all allocated to the institution. c. Ensure that the full cost of care for people living in State Residential Centers is considered when calculating cost neutrality. It is important that the cost of that community service be included in the cost of institutional care, as it is an important component of the cost of care for those individuals. d. Recommend that the full cost of care for individuals residing in State Residential Centers be included in cost neutrality calculations to ensure accurate and equitable comparisons	Clarification	In response to the Centers for Medicare and Medicaid Services' (CMS's) requirement to demonstrate §1915(c) waiver cost neutrality, the DDA requested that The Hilltop Institute (Hilltop) provide a cost neutrality analysis for the DDA waivers. Hilltop provided actual cost and utilization data to assist with waiver amendment estimates for Factor D, D', G, and G' estimates for waiver years (WYs) 3 to 5 that parallel state fiscal years (FYs) 2026 through 2028. The following five factors are used to demonstrate §1915(c) waiver cost neutrality: • Factor C is the number of unduplicated waiver participants during each Waiver Year (WY). • Factor D is the estimated annual average per capita Medicaid cost for home and community-based services (HCBS) for individuals in the waiver program. • Factor D' (pronounced "Factor D Prime") is the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. • Factor G is the annual average per capita Medicaid institutional costs for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) care (or appropriate setting) that would be incurred for waiver participants in the absence of the waiver. • Factor G' (pronounced "Factor G Prime") is the annual average per capita Medicaid costs for all institutional care

		not included in Factor G for waiver participants in the absence of the waiver. The cost neutrality formula applied in the aggregate to each waiver is D + D' <= G + G'. Using the Medicaid Management Information System (MMIS2), Hilltop generated DDA Waiver Center for Medicare and Medicaid Services (CMS) 372 Lag Reports for FY 2019 to 2023. These Center for Medicare and Medicaid Services 372 reports include the unduplicated participants by Fiscal Year, DDA waiver service costs by unduplicated waiver participants and service, and Medicaid costs for all other services provided to individuals in the waiver program. Additionally, using MMIS2 claims data, Hilltop identified Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) providers and pulled unduplicated residents, total days of care, average length of stay (ALOS), and total Medicaid institutional expenditures with the stay span for Fiscal Year 2021 to Fiscal Year 2024. Medicaid Management Information System (MMIS2) claims data includes the Medicaid reimbursement rate paid to providers. Medicaid Management Information System (MMIS2) claims data does not include payments for non-Medicaid services or services funded by state only dollars. Using the actual Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and waiver expenditures, average length of stay (ALOS), methodology recommendations Hilltop provided, and guidance from the Center for Medicare and Medicaid Services Technical Guide, DDA independently calculated the required waiver cost neutrality factors as outlined in the waiver amendment posted for public comment on June 9, 2025. The methodology used for each factor is detailed below: Factor D – the DDA independently calculated Factor D estimates to account for the merger of the three approved DDA waivers

		(Community Pathways, Community Support, and Family Support) into a single waiver. The estimates were based on LTSS*Maryland* Fiscal Year 2025 and FY 2026 person-centered plan data and actual Fiscal Year 24 and Fiscal Year 25 paid claims Factor D' – the Fiscal Year 2023 Community Pathways Waiver CMS 372 Report's average annual per capita cost for non-waiver services forms the basis for Factor D'. This factor was trended 3% annually, reflecting the percentage change from 2023 to 2024 in the Consumer Price Index (CPI) for Medical Care in the Mid-Atlantic area. Factor G – based on the actual ICF-IID stay and Medicaid expenditure cost data, the Per Member Per Day (PMPD) cost was calculated and annualized using the average length of stay (ALOS) in the Community Pathways Waiver (358 days). This cost was then trended 3% annually, reflecting the percentage change from 2023 to 2024 in the Consumer Price Index for Medical Care in the Mid-Atlantic area. Factor G' – based on the actual Medicaid non-Individuals with Intellectual Disabilities (ICF-IID) costs incurred during an Individuals with Intellectual Disabilities (ICF-IID) stay, the Factor G' per member per day cost was calculated and annualized using the average length of stay (ALOS) in the Community Pathways Waiver (358 days) and then trended 3% annually based on the percent change from 2023 to 2024 for the Consumer Price Index for Medical Care in the Mid-Atlantic area.
2. Audits a. Analyze equity implications of new eligibility group logic. b. Require periodic review of whether participants in each group are denied services due to cost modeling.	Not accepted	The DDA will consider this recommendation for a future amendment, with stakeholder engagement.

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Miscellaneous

Miscellaneous		
1. Cost Containment Strategy a. When aiming to reduce costs, prioritize aligning service hours with participants' actual support needs by considering both their level of independence and their Health Risk Screening Tool (HRST) level. Participants with higher independence may require fewer hours, while those with greater care complexity should be prioritized for full service authorization.	Accepted	This recommendation will be shared with the Program Sustainability Taskforce.
2. Participant File a. Provide clear definitions and guidance regarding the 'participant's file,' including where it is maintained, who has access to it, and the process for making amendments. b. Clearly define the difference between the "participant's file" and the "person-centered plan" and specify which parties (individuals/families, CCSs, providers, etc.) have access to which information.	Clarification	Each participant has an electronic health record file within LTSS*Maryland* - which is referenced as the Participant File. "LTSS*Maryland*" is a customized, integrated care management tracking system that manages real-time medical and service information regarding Medicaid participants. For the DDA-operated programs the LTSS*Maryland* file includes various components including the Person-Centered Plan, Client Attachment, Individual Record, Provider Portal, eligibility, and more. State staff, Coordinators of Community Services, and DDA-licensed/certified providers enter and also have access to information. Coordinators of Community Services and DDA-licensed/certified providers provide electronic copies of information that may be included in LTSSMaryland to participants

		and representatives such as the Person-Centered Plan and Provider Support Implementation Plan. Since information is in various sections of the LTSS*Maryland* participant file such as Client Attachments, case notes, and others and not always within the Person-Centered Plan, the reference was changed.
3. Self-Directed Services - Medicare Part B Insurance Coverage b. Include Medicare Part B coverage in the Self-Directed Services (SDS) Employee Health Insurance Premium reimbursement program.	Not Accepted	The DDA will seek input from the stakeholders on reasonable and customary benefits to include related to health insurance.
4. Provider-Managed Service Delivery Model a. We commend the DDA for the adoption of the term "provider managed" in place of "traditional" services, which more accurately reflects the service model b. Agree with changing terminology relating to services a person accesses through a DDA licensed or certified provider from "traditional" to "Provider Managed Service Delivery Model"	Accepted	The DDA appreciates this feedback.
5. Training a. Include training regarding how to support someone to make informed decisions. This should include training on how to explain service delivery options in an unbiased way. b. Amend the waiver to allow direct support staff to begin providing services during an approved training period, as long as they are supervised by staff who have completed the required trainings c. Ensure that training requirements have an achievable	Accepted with amendment	The DDA will explore additional training for direct support professionals, Coordinators of Community Services, Support Brokers, DDA providers, and Financial Management and Counseling Services providers on supporting individuals in making informed decisions. Training standards will be shared with all stakeholders and include implementation timelines and tracking strategies.

timeline for implementation, with a 12-month timeline for changes that impact a large number of staff d. The DDA should have internal processes to track and audit whether proper training was completed. e. The DDA should provide a standard training template or checklist to ensure consistency across providers and reduce administrative burden. This will help ensure compliance while allowing flexibility for provider-specific circumstances.		
6. Self-Directed Services Wage Exceptions a. Recommendation: Do not allow wage exceptions for parents.	Clarification	As per the Self Directed Services Comprehensive Policy and Self-Directed Services Manual: • Participants, with the support of their team, may request an exception to the established reasonable and customary staff wage range standards, up to no more than the established exception rate. The DDA will further engage with stakeholders regarding this recommendation.
7. Billing a. Include in the waiver, that a staff person can only bill for one person at a time.	Accepted with amendment	The DDA will update billing guidance for applicable services.
8. Virtual Supports a. We recommend clear guidance from the state on provider liability related to virtual emergency situations particularly when a medical emergency arises that could not have been reasonably predicted or detected virtually. Providers must not be held liable for outcomes beyond their control when delivering services through approved modalities	Clarification	Virtual supports as a service delivery model is a business decision by the provider. Prior to the provision of virtual supports, the provider must have written policies, train direct support staff on those policies, and advise participants and their person-centered planning teams regarding those policies that address: a. Identifying whether the participant's needs, including health and safety, can be addressed safely while they are using Supports provided virtually;

		b. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the participant experiences an emergency; and c. How a participant will get emergency interventions if the participant experiences an emergency, including contacting 911 if necessary. Additionally, support provided virtually cannot be used to assess a participant for a medical emergency.
9. Safeguards for Minor Children a. DDA should preserve a distinct waiver or clearly defined category within any consolidated Medicaid waiver structure to protect the specific needs of minor children with developmental disabilities. a. Consolidation efforts must include legal safeguards that maintain parental rights, prevent the inappropriate application of adult-focused policies, and ensure equitable access to services. b. Mechanisms should be established to monitor service delivery and funding distribution for children to prevent underrepresentation and ensure adequate support	Clarification	The consolidated waiver supports individuals of all ages and includes federally required safeguards. The Medicaid waiver includes several strategies to assess performance measures including but not limited to: quality and service reviews, State and federal audits, and National Core Indicators surveys.
10. Grandfathering Clause a. The state should include a grandfathering clause to protect families with effective existing arrangements or allow individual waivers based on behavioral and psychiatric history to ensure continuity of care.	Not accepted	Services are authorized based on assessed needs and waiver requirements.

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11. Reasonable and Customary Rate Tables For Employees a. Increase the reasonable and customary rates for employees to make more than $32.00 per hour	Not Accepted	Reasonable and customary rates are established by the DDA. The table for reasonable and customary rates can be found in the Self-Directed Services Manual, and not in the waiver amendment.
12. LTSS*Maryland* a. Improve LTSS*Maryland's* usability and interoperability. Increase the ability for the person, provider, and the Coordinator of Community Services to view and exchange documentation in a fashion that creates a comprehensive participant record.	Accepted	Thank you for this comment. DDA continuously looks at ways to improve LTSS*Maryland* and make improvements that are identified.
13. Service Authorization and Billing Procedure Guidance a. Revise the current authorization and billing procedures for Meaningful Day Services to ensure flexibility and participant choice is reflected in their ability to choose between Community Development Services and Day Habilitation Services on a daily basis. b. Ensure equity in the rates for Community Development Services and Day Habilitation services through an approved combined 40-hour weekly cap across both services. c. Maintain participants' flexibility and control over their services. d. Simply administrative processes.	Accepted with amendment	The Guidelines for Service Authorization and Provider Billing Documentation will be updated to reflect changes in the amendment, simplify processes, and continue to support flexibility for participants. The DDA will further engage with stakeholders on strategies associated with Meaningful Day Services.
14. Service Prohibitions a. Remove or streamline exhaustion of funding prerequisite to avoid unjustified delays in access.	Clarification	The Medicaid program functions as the payer of last resort. Prior to accessing DDA funding for this service, all other available and appropriate funding sources must be explored and exhausted to the extent applicable.

		Prior to accessing DDA funding for this service, all other available and appropriate funding sources which may include, as applicable, private insurance, services offered by Maryland Medicaid State Plan, Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), Department of Human Services (DHS), and any other federal or State government funding program, must be explored and exhausted to the extent applicable. The Coordinator of Community Services can assist in identifying other sources of funding.