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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information

A. The **State** of **Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Community Pathways Waiver

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

D. Amendment Number:MD.0023.R08.06

E. Proposed Effective Date: (mm/dd/yy)

10/06/25

Approved Effective Date: 10/06/25
Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

1. Streamline and enhance service delivery by merging the Family Supports Waiver, Community Supports Waiver, and Community Pathways Waiver into a single, comprehensive program—the Community Pathways Waiver. 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.

2. Ensure greater transparency; streamlined service delivery; ensure funding is outcome-driven and sustainable; meet federal assurances, and reinforce regulatory compliance within the Medicaid waiver program.

3. Incorporate and clarify program standards and requirements. This includes in-person health, welfare and service monitoring visits. It also includes incorporating policy standards such as meaningful day services, training, and competitive integrated employment requirements.

4. Update language to reflect the participant and their legally authorized representative may make decisions. Current language reflects the participant “or” their legal representative which may mislead others to believe the participant is not able or part of the decision making process.

5. Update services including increasing types of qualified providers, clarifying the authorization of dedicated supports, and clarifying service standards.

6. Update performance measures to include data from the National Core Indicators In-Person Surveys and the Quality Improvement Organization Reviews.

Appendix B
1. Updated eligibility to include all ages. Expanding eligibility to all ages ensures that more individuals can access the services they need, and promotes person-centered services.
2. Updated total number of unduplicated participants incorporating the Family Supports and Community Supports participants.

3. Updated reserve categories based on trends, priorities, and funding. The purpose is to help allocate resources based on current needs and priorities. Updates include:

a. Adding a new Deinstitutionalization category for individuals that do not meet the Money Follows the Person requirements.

b. Discontinuing the Waiting List Equity Funds and End the Waiting List Act categories. Each year hundreds of individuals are taken off the waiting list and enrolled in the waiver exceeding these previous proposed figures.

c. Discontinuing the Family Support Participants with Increased Need and Community Support Participants with Increased Need categories as they are no longer needed with consolidation of programs.

d. Increasing Money Follows the Person and State Funded Conversions to support increased community transitions and maximize funding.

e. Increasing Transitioning Youth with reserved categories from the Community Supports waiver.

4. Adding new Medicaid eligibility groups including pregnant women; infants and children under age 19; and foster care.

5. Updated performance measure to include information gained from the Quality Improvement Organization Targeted Case Management Reviews. The Quality Improvement Organization conducts Targeted Case Management Reviews and analyzes information regarding individual and systemic deficiencies. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement. DDA considers recommendations and has made updates to improve policies, waiver proposals, including improving performance measures based on this data.

Appendix C

1. Throughout the amendment, changes were made to enhance clarity, improve accessibility, promote equity, and align services with current policies and regulations. Key changes include clarifying and/or updating service requirements; training and provider qualifications; virtual support provisions, and performance measures. Updates also include removing outdated language and

enhancing plain language.

2. Updates include strengthening guidelines on accessing private insurance before utilizing Medicaid waiver services. Clarifying that all individuals paid to provide Medicaid waiver services are considered Medicaid Providers and must comply with all applicable laws and regulations.

3. Clarifying dedicated supports can be provided for up to 6 months to new participants who have a documented behavioral need while a Behavior Support Plan is developed. Removing provisions allowing the DDA Deputy Secretary to waive provider qualification requirements to ensure all providers meet the same standards. Performance measures were updated to include information gained from the National Core Indicators In-Person Surveys and Quality Improvement Organization Targeted Case Management Reviews. Additionally language was added to define what constitutes extraordinary care and to establish safeguards regarding when and how a legally responsible person and relative can provide services.

Service Updates
1. Assistive Technology and Services –
a. Added Shift Enabling Technology Certification as an acceptable certification for a qualified Assistive Technology Specialist, expanding the pool of qualified providers.
b. Added monthly service fees as a covered service to support monthly fees associated with operating technology.
c. Removed personal emergency response systems as this service is covered under the Medicaid Community First Choice program.

2. Behavioral Support Services:
a. Expanding the pool of qualified providers:
(1) Removed requirements for high school or equivalent/higher for staff providing the Brief Support Implementation Services.
(2) Expanded qualified professionals that can complete the behavioral assessment and provide consultations to include a Licensed graduate-level professional counselor working under the license of the Licensed clinical professional counselor (LCPC) and Licensed masters-level social worker working under the license of the LCSW-C.
b. Improving quality of services:
(1) Clarified that recommendations for dedicated 1:1 and 2:1 support, enhanced supports, and overnight services must be in a Behavior Support Plan.
(2) Clarified Behavioral Consultation includes graphing and analysis of collected data to identify trends and patterns of target behaviors.
(3) Clarified requirements for progress notes.

3. Community Living - Enhanced Supports and Community Living - Group Home
a. Added language about dedicated supports can be provided for participants new to services and participants in services who have specific documented behavioral, needs for up to 6 months while a Behavior Support Plan gets authorized and developed. This allows participants to get necessary services during the development period and eliminates gaps in services.
b. Removed requirement for staff to have GED or high school diploma, expanding the pool of qualified providers.

4. Day Habilitation
a. Clarified that supports may be provided virtually in a participant’s private residence and other DDA residential living arrangements, which allows greater access to services.
b. Added language that dedicated supports can be provided for participants new to services and participants in services who have specific documented behavioral needs for up to 6 months while a Behavior Support Plan gets authorized and developed. This allows participants to get necessary services during the development period and eliminates gaps in services.

5. Employment Support Services
a. Incorporates information from the DDA’s Meaningful Day Services Policy including but not limited to:
(1) Clarified Discovery milestone requirements;
(2) Clarified Job Development includes strategic combination of both direct and indirect services;
(3) Clarified Ongoing Job Supports and Follow-Along Supports can be provided via remote technology (for example: Skype or Facetime) if preferred by the participant; and
(4) Clarified 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.
b. Incorporates information from the DDA’s Competitive Integrated Employment Policy.
c. Clarified when seeking service authorization and/or re-authorization for Employment Services through Follow-Along Job Supports and/or Ongoing Job Supports, that a participant’s job must have the qualities of competitive integrated employment.
d. Clarified service authorization for the Provider Managed Service Delivery Model.

6. Environmental Assessment - Clarified that an authorized annual assessment is based on plan year.

7. Environmental Modifications
a. Added Smart home devices that require attachment to the home, such as voice activated door openers, blinds and shade openers as an option. This allows participants to access needed services and promotes independence.
b. Deleted age requirement for qualified provider, expanding access to services.

8. Family and Peer Mentoring Supports-
a. Language was clarified, as previously there had been confusion around the definition of mentors.
b. Removed the requirement for Bachelors Degree and added requirement for lived experience as a standard for family and peer mentors, recognizing life experiences (and not educational experience) as integral to peer supports.

9. Family Caregiver Training and Empowerment Services – added Organized Health Care Delivery Services as a qualified provider option.

**********CONTINUED IN "MAIN-B - OPTIONAL" DUE TO SPACE LIMITATIONS**********

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	
☒ **Appendix A - Waiver Administration and Operation**	Quality Improvement Strategy
☒ **Appendix B - Participant Access and Eligibility**	B-1, 2, 3, 4, and 6
☒ **Appendix C - Participant Services**	C-1/C-3: Service Specification; C-2:General Service Specifications; C-5: Home
☒ **Appendix D - Participant Centered Service Planning and Delivery**	D-1 and 2
☒ **Appendix E - Participant Direction of Services**	E-1 and 2
☒ **Appendix F - Participant Rights**	F-1 and 2
☒ **Appendix G - Participant Safeguards**	G-1 and 2
☒ **Appendix H**	H-2 and 3

Component of the Approved Waiver	Subsection(s)
☒ Appendix I - Financial Accountability	I-1,2, and 3
☒ Appendix J - Cost-Neutrality Demonstration	J-1 and 2

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

- ☐ **Modify target group(s)**
- ☒ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Community Pathways Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MD.0023
Waiver Number:MD.0023.R08.06
Draft ID: MD.012.08.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

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

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

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

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

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

Waiver Organizational Structure:

The MDH is the single state agency ultimately responsible for administering MD's Medical Assistance Program. The MDH's OLTSS is responsible for ensuring compliance with federal and state laws and regulations in the operation and administration of this and other Waiver programs. The MDH's DDA is the OSA operating this Waiver program and providing funds for community-based services and supports for eligible individuals with developmental disabilities in the State of Maryland. The DDA has a Headquarters and four Regional Offices across the State: Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support administrative tasks, operations, and direct service delivery. Medicaid State Plan TCM services are provided by certified CCS provider organizations. The MDH's OHCQ performs licensing, surveys, and incident investigations of many of the DDA's licensed HCBS providers. The MDH's OIG investigates allegations of overpayment or fraud.

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

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

Services are provided by individuals or provider organizations (i.e., private entities and local health departments) that meet applicable requirements in Appendix C prior to rendering services. For Provider Managed Services Delivery Model, individual providers and provider organizations are licensed or certified by the MDH; for the Self-Directed Services Delivery Model, the individual provider or provider organization must be certified or licensed by the MDH and confirmed by the FMCS provider as meeting applicable requirements. Providers offering career exploration, facility-based supports, day habilitation, licensed respite, community living-group home, and community living-enhanced supports waiver services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the participants own home such as employment services, personal supports, respite, and assistive technology and services must meet provider qualifications to be certified by the DDA. Financial Management and Counseling Services providers and Support Broker services are also provided for participants that use the Self-Directed Service Delivery Model. This organizational structure provides a coordinated community-based service delivery system so that participants receive appropriate services oriented toward the goal of full integration into their community.

The DDA has a contract with an entity that is certified by Centers for Medicare and Medicaid Services as a Quality Improvement Organization to:
1. Provide strategies that enhance the quality of life and help to ensure the health and wellbeing for individuals with intellectual

and developmental disabilities.
2. Develop audit standards for the DDA's services including review cases and analyze patterns of services related to assessed need and quality review.
3. Conduct ongoing utilization reviews to safeguard against unnecessary utilization of care and services and to assure efficiency, economy, and quality of care.
4. Administer the DDA's National Core Indicators Surveys.
CONTINUED IN MAIN B OPTIONAL DUE TO LACK OF SPACE*

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the

Act *(select one)*:

◉ **No**

○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the

procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

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

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

The DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups related to employment, self-direction, technology, supporting children and families, person-centered planning, coordination of services, training, system platforms, and rates. These partnerships provide opportunities to obtain additional information, input, and recommendations from participants that can influence services offered by this Waiver program and applicable policies and procedures.

The DDA established a Waiver Advisory Council which creates meaningful engagement and a feedback loop with all interested stakeholders, with a focus on people with lived experiences. Members include people with lived experience in both provider managed and self-directed services (50%), family members, community providers, advocates, and various state agencies. Members have the opportunity to advise and provide recommendations to the DDA on system design, service delivery, and quality enhancement strategies for the DDA-operated Medicaid waiver programs. The WAC 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 QE efforts and improvement strategies. A Waiver Recommendation Workgroup was established in October 2024 to develop and share recommendations with the WAC during the February 21, 2025, April 17, 2025, and June 26, 2025 meetings.

Waiver Amendments Announcement and Dedicated Amendment Website

DDA sent out an announcement of the amendments on June 8, 2025. DDA established a dedicated Waiver Amendment #3 2025 webpage and posted information about the proposed waiver amendment including the draft documents, which show tracked changes for stakeholders to easily see the edits made to the currently approved waiver. The website is located at: Community Pathways Waiver - Amendment #3 2025 link:https://tinyurl.com/24k6eb63. The announcement was posted on the Medicaid Home and Community-Based Services website located at: https://tinyurl.com/ykhf3mdc. In addition, hard copy notifications were posted at the Maryland Department of Health and at each DDA Regional Office. Hard copies of the proposed updates were available for public review and comment via request submitted to wfb.dda@maryland.gov.

Amendment Webinars and Stakeholder Engagement
DDA also provided information and further engaged with stakeholders during five stakeholder webinars and during the June 26, 2025 WAC meeting. The webinar presentations and recordings are posted to DDA YouTube Channel and on the dedicated amendment website and Waiver Advisory Council website (link - https://tinyurl.com/yecd4ryk). A frequently asked question document was created, shared with stakeholders, and posted on the amendment website.

Public Comment Period
The official public comments period was held from June 8, 2025 through July 9, 2025. The Maryland Urban Indian Organization for Tribal Consultation was notified on June 9, 2025 of the posting of this application and the public comment period. Due to challenges with initial uploads to DDA website, Respite Services and Supported Living were not posted on June 9, 2025. To address this, the public comment period was extended until July 13, 2025, for Respite Services and Supported Living amendment proposals only. Public comments were submitted to wfb.dda@maryland.gov or mailed to DDA Federal Programs at 201 West Preston Street, 4th Floor, Baltimore MD 21201. DDA received 255 unduplicative responses from various stakeholders including individuals, families, providers, and advocacy agencies and other public members.

Public Input Summary
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.
Introduction/Purpose of the Amendment & Appendix A – Waiver Administration and Operation
Comments received in support of consolidation of DDA-operated Medicaid waiver programs: Easier for participants to navigate DDA's services; Addresses the confusion and duplication of the existing system while increasing efficiency and effectiveness; Processes involved in getting people into the system will be simpler and more efficient; Support increased access to services for all eligible individuals in the state of Maryland; Will lead to more time for person centered holistic planning; Simplify and streamline the various processes within the waiver; Common-sense approach to current realities facing both self-directed and traditional services. Comments received in opposition of consolidation of DDA-operated Medicaid waiver programs: The proposed reforms seem to add more layers of complexity without any real consideration to simplify delivery; Keep the Family Supports Waiver.

In response to comments about stakeholder engagement, DDA will continue to engage with people with lived experiences and other stakeholders in the development of amendments. DDA will continue to seek input from stakeholders and the WAC. The WAC has representation from people and families with lived experience, advocates, providers, and CCS Services, from all over the State of Maryland. 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.

**********CONTINUED IN "MAIN-B-OPTIONAL" DUE TO SPACE LIMITATIONS**********

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

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

7. Contact Person(s)

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

Last Name: Smith

First Name: Jamie S.

Title: Director

Agency: Maryland Department of Health - Office of Long Term Services and Supports

Address: 201 West Preston Street

Address 2: RM 127

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-1431 **Ext:** ☐ **TTY**

Fax: (410) 333-6547

E-mail: jamie.smith1@maryland.gov

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

Last Name: Workman

First Name: Rhonda

Title: Director of Federal Programs

Agency: Maryland Department of Health - Developmental Disabilities Administration

Address: 201 West Preston Street

Address 2: 4th Floor

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-8692 **Ext:** ☐ **TTY**

Fax: (410) 333-5850

E-mail: Rhonda.Workman@maryland.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Alisa Jones

State Medicaid Director or Designee

Submission Date: Sep 11, 2025

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

Last Name: Briskin

First Name: Perrie

Title: Deputy Secretary

Agency: Maryland Department of Health

Address: 201 W. PRESTON ST.

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (443) 970-0547 **Ext:** ☐ **TTY**

Fax: (410) 767-6489

E-mail: Perrie.Briskin@maryland.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☒ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☒ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☒ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

To streamline and enhance service delivery, the Maryland Department of Health is merging the Family Supports, Community Supports, and Community Pathways waiver programs into a single, comprehensive program—the Community Pathways Waiver. 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. Participants will continue to receive their services without having to take any action related to eligibility or planning.

All the services available under the Family Support and Community Support waivers are available under the Community Pathways waiver. There are no differences.

A. Participants and Stakeholder Communications and Supports
1. Participants will receive a letter from the Department informing them of the transition to the Community Pathways programs at least 30 days prior to the transition.
2. A frequently asked question document will be created, updated, and shared with stakeholders.
3. DDA will share information during community webinars and within the DDA Connections newsletter.
4. DDA will partner with advocacy organizations to also share information.
5. Information regarding the amendment and frequently asked questions will be noted on a dedicated Department webpage.
6. Coordinators of Community Services and DDA Regional Offices are also available to answer questions.

B. Technology Systems
Maryland has four main information technology systems that interface related to waiver processes including but not limited to: case management, Person-Centered Plans (Service Plans), waiver applications, eligibility, provider enrollment, and provider claims submission. The systems include LTSSMaryland, MDThink Eligibility and Enrollment (E&E), Medicaid Management Information System (MMIS), and ePREP.

The following actions will occur for all participants in the Family Supports and Community Supports waiver programs to ensure no disruption in services:

1. MDThink Eligibility and Enrollment (E&E) system data patches will be used to:
a. End enrollment in the Family Supports and Community Supports waiver programs with an effective date of October 5, 2025 and
b. Add enrollment into the Community Pathways waiver program with an effective date of October 6, 2025.
c. The updates will be completed over a dedicated release window in order to execute the data patches.
D. All pending applications and appeals will be converted to the Community Pathways program.

2. LTSSMaryland system:
a. Program enrollment information will be transmitted from the MDThink Eligibility and Enrollment (E&E) and Medicaid Management Information System (MMIS).
b. System updates and data patches will convert all applications, Person-Centered Plans, forms, and appeals associated with the Family Supports and Community Supports waiver programs participants to reflect the Community Pathways waiver program.
c. The updates will be completed over a dedicated release window in order to execute the data patches.

3. Medicaid Management Information System (MMIS)
The data patches will be transmitted from MDThink Eligibility and Enrollment (E&E) to the Medicaid Management Information System, which will then be transmitted from Medicaid Management Information System to LTSSMaryland.

4. Electronic Provider Revalidation and Enrollment Portal (ePREP):
The ePREP system is used for individual and community providers to apply and enroll to become a Medicaid provider including Medicaid waiver program providers.
a. The DDA will confirm all current Family Supports and Community Supports providers are also enrolled under the Community Pathways program.
(1) Technical assistance will be provided for any providers that are not current Community Pathways providers.
(2) Participants, whose providers choose not to become a Community Pathways provider, will be supported in choosing new providers.
b. System updates will be completed to add new provider types for individual behavior support specialists and nurses for enrollment into Medicaid.
c. New categories of service will be added for individual providers who bill through the Financial Management and Counseling Services providers.
d. A streamlined process for enrollment of these new provider types will be utilized to support expedited provider enrollment.

e. Information and guidance will be shared with providers, participants, and families.

C. Mandatory Self-Direction Training Requirement
In the fall, the DDA will begin sharing information regarding the mandatory DDA self-directed orientation/training required for all new applicants interested in self-directing their services and participants using the Provider Managed Service Delivery Model interested in the self-directed service delivery model. The specific DDA Self-Directed Training series module will be required. Examples include: Module 1: Self-Direction Overview; Module 2: The Self-Directed Services Team; and Module 3: Person-Centered Planning.
a. The mandatory self-directed orientation/training must be completed before enrollment. There is no cost to participants to attend.
b. 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.

D. Individual and Family Directed Goods and Services
Participants currently authorized funding above the $5,000 limit may access the authorized funding through the end of their Person-Centered Plan.

E. Assistive Technology - Personal Emergency Response System
Currently there are a few individuals receiving Personal Emergency Response System supports under the DDA-operated Medicaid waiver programs. The DDA and Community First Choice program will coordinate and track the transition of Personal Emergency Response System supports. Program case managers (i.e., Coordinators of Community Services and Support Planner) will support participants and their teams with the transition. Case managers will create and/or review Person-Centered Plans and Plans of Services to reflect the change in service program.

**********PUBLIC INPUT CONTINUED FROM MAIN-B-OPTIONAL DUE TO SPACE LIMITATIONS**********
DDA clarified provision of allowing enhanced rates for up to 6 months while a development and authorization of a BSP; however if it takes longer than 6 months, the enhanced rate will not be authorized. DDA provided information about appeal rights. DDA did not accept changing the definition of challenging behavior. Clarified what constitutes a 'trial experience.' A Trial Experience is available for individuals (either prospective or current participants) considering either Community Living – Group Home or Community Living – Enhanced Supports services. DDA clarified group size and that dedicated supports are outlined in a participant's PCP.

Day Habilitation (DH)- DDA did not accept comments relating to updating the self-directed services manual. DDA also shared a visual guide in assisting stakeholders with understanding differences between transportation included in Meaningful Day Services and standalone Transportation Service. DDA explained that the self-directed services manual will be reviewed and updated based on waiver amendment.

Employment Support Services (ESS)- DDA clarified comments related to direct and indirect supports, adding that DDA will seek stakeholder input related to additional flexibility and clarity regarding job development indirect and direct supports. DDA will seek stakeholder feedback related to comments regarding service limitations and authorization flexibility for Job Development. DDA not accept comments related to training exemptions or additional payment for training costs, which are included in the rate. DDA did not accept comments about changing frequency of face to face visits, and clarified that virtual supports should be documented in the PCP and in the Service Implementation Plan. In regard to service flexibility, DDA clarified that 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. In reply to comments received related to employee competencies, DDA will consider this recommendations for a future amendment, with stakeholder engagement. DDA did not accept comment related to adding, "but not limited to" to the list of allowable on-going job supports. DDA clarified what each employment milestones include. DDA will consider recommendations related to the different milestones for a future amendment, with stakeholder engagement. DDA clarified language discrepancies.

Environmental Assessment and Modification (EA)- DDA clarified that an annual assessment is not required if the participant is not requesting additional modification. Comments related to adding SMART home devices were accepted. DDA clarified coverage for installation and maintenance. DDA did not accept ongoing consistent funding of Environmental Modifications.

Family and Peer Mentoring Supports - DDA clarified definition for family members 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.

Family Caregiver Training and Empowerment Services - No comments were received for Family Caregiver Training and Empowerment Services

Housing Support Services (HSS)- DDA clarified that indirect services were allowable for housing support services. DDA added a virtual support option based on feedback from stakeholders.

**********Please note this is not an exhaustive summary. A comprehensive, detailed public input summary was provided to CMS via an email attachment on 7/17/25..please review **********

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

**********CONTINUED FROM "PURPOSE OF THE AMENDMENT" DUE TO SPACE LIMITATIONS**********

10. Individual and Family Directed Goods and Services (IFDGS) –

a. Clarified that the purchase of Individual and Family Directed Goods and Services represents the most cost-effective means of meeting the identified need.

b. Clarified fitness items that can be purchased at most retail stores not to exceed $1,000 per item;

c. Clarified specific items must be related to the person's disability, recommended by a medical professional, and not covered by health insurance.

d. Clarified dental services recommended by a licensed dentist and not covered by health insurance such as dental anesthesia and denture services are covered.

e. Clarified tickets, memberships, and related costs to attend recreational activities and events, such as museums, zoos, bowling, and indoor skydiving are not covered.

f. Clarified reimbursement is based on reasonable and customary fees.

g. Clarified goods or services with costs that exceed reasonable and customary costs and community norms for the same or similar good or service are not covered.

h. Clarified that if integrated programs or activities are available to the public, free, or at a lower cost they must be accessed first.

i. Clarified programs and activities that are exclusive for individuals with disabilities are not covered.

j. Clarified, as per federal Medicaid waivers technical guide:

(1) Goods, services, equipment, and supplies that are diversional or recreational in nature fall outside the scope of section Medicaid 1915(c) of the Social Security Act and therefore are not covered; and

(2) Goods, services, equipment, and supplies that a household that does not include a person with a disability would be expected to pay for as household expenses (e.g., subscription to a cable television service) are not covered.

k. Reinstates the initial cap on good and services expenditures at $5,000 per year.

l. Clarified that Day-to-Day Administrative Supports is to provide assistance with participant's household management and scheduling medical appointments, and specifies scope of service, including:

1) Tasks that are included and excluded from the scope of service;

2) That the service cannot overlap with responsibilities of other service providers, including Coordinators of Community Services, Support Brokers, representative payee, guardian of property, and other natural supports; and

3) Requirements for being able to access Day-to-Day Administrative Supports (must be 18 years of age or older and currently unable to do these tasks independently).

m. Day-to-Day Administrative Supports must be linked to a team decision tree checklist for household management tasks and medical appointment scheduling needs included in the Person-Centered Plan.

n. Establishes that Support Broker Services are required when the participant employs any person to provide Day-to-Day Administrative Supports, and that Support Brokers may not provide Support Broker Services and Day-to-Day Administrative Supports to the same participant.

o. Allows relatives to provide Day-to-Day Administrative Supports if they are not also a legal guardian or legally responsible person.

p. Establishes provider qualifications.

q. Limits Day-to-Day Administrative Supports may be provided up to 10 hours per month.

11. Live- In Caregiver Supports - clarified that a sibling, hired by an approved Medicaid provider, can be paid to provide the service.

12. Medical Day Care - add option to receive Behavioral Supports Services during Medical Day Care services.

13. Nursing Support Services –

a. Clarified Health Case Management does not include delegation of medications and medical/health/nursing treatments.

b. Clarified as per Code of Maryland Regulations 10.27.11, the delegating nurse shall be readily available when delegating a nursing task to an unlicensed individual, certified nursing assistant, or medication technician, and to address the participant's health needs as may arise emergently.

c. Removed requirement for 24/7 availability or provide qualified back-up services.

d. Updated requirement for DDA Registered Nurse Case Manager/Delegating Nurse (CM/DN) Orientation training to be completed prior to service delivery.

14. Participant Education, Training, and Advocacy Services - Removed individual participant support professionals and added Organized Health Care Delivery System as a qualified provider.

15. Personal Supports

a. Clarified that Personal Supports enhanced cannot be provided virtually.

b. Removed limitation of 82 hours for provider managed service delivery model.
c. Clarified the DDA may authorize an enhanced rate, 2:1 supports, and overnight services 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.

16. Remote Support Services - 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. This gives participants great autonomy and flexibility over their life.

17. Respite Services
a. Clarified State overnight or youth camps must be certified by the Maryland Department of Health.
b. Clarified respite may not be provided by the primary caregiver.

18. Support Broker services –
a. Updated description and requirements based on the federal Center for Medicare and Medicaid technical guide. The updates are to simplify the information and to prevent duplication of activities with case managers and Day-to-Day Administrative Supports. Participants will receive the same level of support with no additional cost to the participant.
b. Clarified that service assists the participant with supported decision making related to employment related subjects.
c. Enhanced qualified providers to include required training and code of conduct.
d. Clarified non-billable administrative tasks.
e. Included that Support Brokers are required when the participant selects a relative, legal guardian, or legally responsible person as their designated representative, or when the participant employs any person or Provider to provide Day-to-Day Administrative Supports.
f. Removed requirement for First Aid and CPR.

19. Supported Living - the DDA may authorize dedicated support for participants new to services and participants in services who have specific, documented behavioral needs for up to 6 months while a Behavior Support Plan gets authorized and developed.

20. Transition Services – added the option to include the cost for training direct support professionals who will be supporting participants with complex medical or behavioral needs prior to the transition date to ensure health and welfare on the first day of community services.

Appendix C-1
1. Clarified training for Coordinators of Community Services, in alignment with Code of Maryland Regulations 10.09.48. Training includes expectations related to integration and full access to the greater community, community setting rule, and person-centered planning.
2. Outlined the provision of virtual supports as an electronic method of service delivery, and defines how virtual supports are used to facilitate community integration, enhance the effectiveness of service delivery, improve accessibility, and ensure health and safety.

Appendix C-2
Included information related to the Quality Improvement Organization oversight responsibilities which include quality reviews and auditing of provider qualifications.

Appendix C-5
1. Defined relative as including a grandparent, step-grandparent, sibling, step-sibling, aunt, uncle, niece, and nephew. Clarified definition and scope of “Extraordinary Care” and the scope of legally responsible individuals, relatives, and legal guardians in providing extraordinary care.
2. Updated service delivery by a Legally Responsible Person, legal guardians, and relatives.
3. Clarified a request form and authorization is required before a Legally Responsible Person, legal guardians, and relatives provide services.
4. Clarified that the Legally Responsible Person, legal guardians, and relatives will actively support hiring of employees or providers.
5. Clarified safeguards related to participant satisfaction, health and welfare through Coordinators of Community Services quarterly monitoring and follow-up activities.
6. Updated list of waiver services furnished by relatives/legal guardians to align with employer authority services options.
7. Clarified that services provided by a Legally Responsible Person, legal guardians, and relatives are subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

8. Clarified legal guardians, paid to provide guardianship services, may not provide paid Medicaid waiver program services to a participant.
9. Clarified what Medicaid waiver program services can be provided in the acute care hospital setting, and when direct support may be provided in those settings, to support the participant's personal, behavioral, and communication supports not otherwise provided in that setting.

Appendix D
1. Clarified an individual is ineligible for employment by a Coordination of Community Services provider organization if they are simultaneously providing services under a DDA-operated Medicaid waiver to a participant as the participant's employee or as the employee of a vendor or provider.
2. Clarified within each quarter of the Person-Centered Plan Annual Plan Date, at a minimum, the Coordinator of Community Service must monitor service delivery in person at the place of service as specified in the approved Person-Centered Plan. The Coordinator of Community Service should visit the person in the setting of the service; and, for each quarterly visit, a different service setting.
3. Updated performance measure to include information gained from the National Core Indicators In-Person Surveys and Quality Improvement Organization Targeted Case Management Reviews.
4. Clarified the Quality Improvement Organization in collaboration with the Council on Quality and Leadership conducts Personal Outcome Measure interviews with participants and Basic Assurance interviews with providers to collect and analyze information regarding individual and systemic deficiencies.
5. Clarified the Quality Improvement Organization also conducts the National Core Indicators Survey and Targeted Case Management Reviews in an effort to measure and improve the performance of DDA's service system. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement.
6. Clarified State staff and Maryland Department of Health agents will conduct site visits, perform utilization reviews, and follow up on health and welfare concerns.

Appendix E
1. Clarified the participant and their legally authorized representative (as applicable) may direct their own services or designate a representative.
2. Added new mandatory DDA self-directed orientation/training for all new applicants interested in self-directing their services 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;
b. To ensure an informed decision prior to enrollment into the Self-Directed Service Delivery Model; and
c. The requirement is for the participant or their Designated Representative to complete the required training modules associated with the Self-Directed Training Series. The participant is not required to complete or pass any test questions associated with the training.
3. Clarified Support Broker services are outlined in Appendix C.
4. Clarified in order to avoid conflicts of interest, a participant may not hire or select to provide services under a DDA-operated Medicaid waiver:
a. An employee who is simultaneously employed by a targeted case management provider or otherwise provides targeted case management services; or
b. A vendor or provider that simultaneously provides or has employees that provide targeted case management services.
c. A support broker that also provides direct support to the same person
5. Clarified that Support Broker Services are required if the participant employs a Day-to-Day Administrative support provider.
6. Clarified 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.
7. Clarified Financial Management and Counseling Services providers must provide timely responses and resolutions to participant requests.
8. Updated the number of participants using the Self-Directed Services Delivery Model with Family Supports and Community Supports participants.
9. Updated safeguards to include the Coordinator of Community Services quarterly and more frequently site visits including wellness checks. The DDA regional office staff including Quality Enhancement and Nurses will conduct site visits to follow-up on health and safety concerns and reported complaints and incidents. The Office of Health Care Quality will conduct site visits and investigations based on complaints and incidents reported.
10. Added that the DDA has the authority to terminate the participant's enrollment in the Self-Directed Service Delivery Model, without the ability to reapply for or enter the Self-Directed Service Delivery Model for any length of time under established circumstances, including when the participant overutilizes authorized services. When participant overutilizes authorized

services, before involuntarily terminating the participant from the self-directed services model, DDA may first:
a. 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
b. Require a corrective action plan.

Appendix F
1. Updated to include the new dedicated “Request a Fair Hearing. File an Appeal” website which includes plain language information, frequently asked questions, and option to submit fair hearing request online at: https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx.
2. Updated case resolution conference to be specifically related to DDA eligibility determinations.

Appendix G
1. Clarified the Office of Health Care Quality (OHCQ) has the authority to investigate all incidents and providers (employees, vendors, and DDA providers).
2. Clarified provider’s internally investigated incidents shall be reported within 1 working day of discovery. The provider agency is responsible for reviewing and investigating each of these incidents. Types of Internally investigated incidents are outlined within Policy on Reportable Incidents and Investigations and include but are not limited to the following: physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment.
3. Clarified the DDA website home page includes a link to information on how to report abuse or concerns. Information can be viewed at: https://health.maryland.gov/dda/Pages/Report%20Abuse.aspx
4. Updated performance measure to include information gained from the National Core Indicators In-Person Surveys and Quality Improvement Organization Health and Welfare Reviews.
5. Clarified the Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.

Appendix H
1. Clarified DDA Waiver Advisory Council with the purpose of creating meaningful engagement and a feedback loop with all interested stakeholders, and with a focus on people with lived experience. Participants will have the opportunity to advise in and provide recommendations to the DDA on system design, service delivery, and quality enhancement strategies for the DDA-operated Medicaid programs.
2. Clarified the Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.
3. Added information related to the DDA seeking to achieve Network Accreditation from the Council on Quality and Leadership. Achieving Network Accreditation uses baseline performance and seeks system transformation by enhancing outcomes people experience.

Appendix I and J
1. Updated performance measures.
2. Clarified rate components associated with Community Living - Group Home, Community Living - Enhanced Supports, and Supported Living including use of the Bureau of Labor Statistics wage job code 21-1093.
3. Clarified payments for all Medicaid waiver program services are made through the approved Medicaid Management Information System.
4. Clarified Medical Day Care claims are submitted electronically for payment into the State’s eMedicaid system which interfaces with the Medicaid Management Information System.
5. Updated assumptions, estimated users, average units, average cost, and total cost.
6. Added that in Waiver Year 3, the budget includes geographical differential rates of 10% above the standard rate for eligible services.

**********CONTINUED FROM Main 2 - Brief Waiver Description due to SPACE LIMITATIONS.**********
Termination of Participation

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

1. No longer meets the eligibility requirements;

2. Voluntarily chooses to disenroll from the Medicaid waiver program;

3. Fails to use a Coordinator of Community Services;

4. Fails to participate in or otherwise complete any assessments or screenings required by the Department, such as the Health Risk Screening Tool within 30 calendars of the due date;

5. Refuses in-person health, welfare, and service monitoring visits from Coordinators of Community Services and Maryland Department of Health staff without good cause, as determined in the DDA's sole discretion;

6. Fails to comply with applicable Medicaid waiver program requirements as set forth in this Medicaid waiver program application, applicable federal and State law and regulations, and Department or Administration policies; or

7. Fails to maintain continuous Medicaid waiver-funded services without a lapse exceeding 183 calendar days, as required by the Waiver application. A minimum of 1 waiver service must be used every 6 months.

8. Dies.

Waiver Re-Enrollment

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

a. The individual meets eligibility requirements; and

b. The Medicaid waiver program has a slot and funding available to support re-enrollment.

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

a. During the same waiver year;

b. Within 90 days of termination; or

c. Subsequent waiver years based on reserved categories and placement on the waiting list.

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

**********Continued from Main-6-Requirements Public Input due to SPACE LIMITATIONS.**********
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.

DDA did not accept comments related to limiting the focus of the waiver amendment. DDA clarified for Medicaid waiver programs a formal 30-day public notice and comment period if required. Comments related to Termination of Participation included: clarifying that Medicaid issues disenrollment notices and determines dates; accepting comment about not requiring the SIS; and not accepting changing timeframe for terminations from 30 to 90 days. DDA did not accept comments to change to waiver re-enrollment standards, as individuals are reinstated based on Medicaid rules. DDA clarified that the federal waiver template is designed to address how the state’s Medicaid waiver program is designed to meet these assurances; the language cannot be changed. DDA did not accept comment to strike or revise all involuntary SDS termination provisions. DDA clarified that participants have autonomy in selecting Support Brokers and negotiating with FMCS. DDA clarified that 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. DDA did not accept publishing DDA–OLTSS Interagency Agreement. In response to a comment about defining enforceable contract terms, including performance penalties and transparency standards, DDA clarified that 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.

Appendix B
DDA received comments related to reserved slots. DDA clarified slot projections and did not accept restoring slots for certain target groups, including state funded services and End the Wait Act 2022. DDA accepted comments related to CCS role in providing information and remaining conflict free. DDA clarified that DDA monitors system data patches used to identify any concerns and remediate related to the waiver consolidation. DDA clarified language related to “institutionalization.” DDA clarified that participants in the traditional model do not need to complete the self-direction training requirement unless they choose to move into that model. Clarified that the state provides translation services, as well as providing methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents. The OAH also sends notices to individuals on how to request accommodations, if necessary. DDA did not accept comments relating to backdating eligibility determinations or Medicaid enrollment. DDA clarified that Autism waiver eligibility is different from DDA eligibility, and participants cannot be added to the waiver automatically. This also applies to granting automatic waiver eligibility to applicants already approved for federal Supplementary Security Income benefits, as DDA eligibility is separate from financial eligibility. DDA provided information about due process. DDA defined "non-compliance" and “health and safety" risks based on comment. DDA clarified that a PCP must be created, reviewed, and approved as part of a transition from SDS model to provider managed model.

Appendix C, General- DDA clarified comments related to the use of dedicated hours. DDA will explore with stakeholders independent scoring mechanisms and validated tools to authorize dedicated hours. 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. DDA did not accept removing requirements for BSP or NCP for dedicated hours. DDA clarified that REM nursing plans cannot be used to justify 2:1 or enhanced supports, as REM is a non-DDA program with different criteria. DDA did not accept comments related to reinstating the clause, “Unless Otherwise Authorized by DDA”; for transparency and consistency, the standards for authorization of dedicated hours are reflected within the amendment and do not have an exception clause. DDA did not accept adding language allowing DDA the ability to authorize residential services for someone under the age of 18. DDA clarified that Medicaid waiver programs include required federal assurance and safeguards related to health and welfare and financial accountability and integrity within Medicaid rules. DDA will explore with stakeholders flexibilities within meaningful day services and service authorization. DDA did not accept comments related to re-approving overtime for live-in family caregivers. DDA clarified that Staff working must satisfactorily complete required orientation and all training designated by DDA; no changes were made. DDA will update the training matrix to align with the waiver amendment and policy. DDA did not accept comments related to keeping HS Diploma/GED requirements for staff; the elimination of HS Diploma/GED for expanding the pool of qualified providers and supports staff training taking priority over degree. There were comments related to adding or removing telehealth services to services. DDA clarified that CMS 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. This does not change how services are being delivered. Comments regarding employee designation as a Medicaid provider were clarified, ‘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.’ DDA will engage with stakeholders on further recommendations related to this.

Appendix C 1 and 2-5 - DDA replied to comments related to provider self-assessment tool, clarifying the requirement. Comments related to removing requirement for a Supported Decision Making Agreement. DDA removed the requirement and added requirement to complete a Substitute Judgement document as a safeguard 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. Comments were received relating to Legal Guardians, LRPs, and Relatives as Paid Staff. DDA clarified that relatives, legal guardians, and legally responsible person can provide no more than 40-hours per week of the service. DDA will enhance training associated with the use of legal guardians, LRPs, and relatives as paid staff, and will further engage with stakeholders on standards and additional safeguards associated with legal guardians, LRPs, and relatives as paid staff. DDA did not accept changing the definition of relative. DDA did not accept offering a monthly stipend to family caregivers, or removing the requirement for LRPs to submit a request form for approval before providing services. Comments related to using the participant agreement will be considered with stakeholder engagement. DDA clarified that the QIO quality review of services include paid services provided by legal guardians and relatives. Clarified that DDA does not require participants to have a legal guardian. Comments related to exempting legal guardians from the extraordinary care requirement were not accepted. DDA clarified that participants retain freedom to choose Self Directed Services or the traditional managed model. DDA received comment related to access and documenting informed choice, and clarified that the choice of service delivery model is documented on the Freedom of Choice form and the PCP which is signed by the participant. The Maryland Department of Health also provides a written letter notifying the individual of its denial decision including Notice: Medicaid Fair Hearing Rights. DDA clarified that participants can file a complaint online by completing an online complaint form. Comments related to compliance oversight and audit findings were clarified; State oversight of compliance is noted within Appendix C. As well, the

QIO shares information at the Waiver Advisory Council Meetings; and a scorecard is being developed by the QIO to provide additional information on participants' outcomes. In response to a comment about the Home and Community-Based Settings, DDA provided a link to information regarding the Home and Community-Based Settings oversight and monitoring.

Assistive Technology and Services (AT)- Recommended revisions to the service definition of AT and service requirements were not accepted. However, DDA received will further engage with stakeholders for updates. DDA agreed to add Shift Enabling Technology Integration Specialist (ETIS) Certification to the provider qualifications. DDA did not accept recommendations related to not requiring an AT assessment. DDA did not agree to comments related to removing Personal Emergency Response Systems (PERS), as it is available through CFC. DDA did not accept comments related to adding virtual supports, or consolidating Remote Supports Services and Assistive Technology into a single service. DDA agreed with the recommendation related to training on AT and clarified that it is not limited to a one time request. Comments related to expanding the provider population will be considered for future amendment, with stakeholder engagement. DDA did not accept changes to qualified provider requirements.

Behavioral Support Services (BSS)-Comment related to creating a behavioral support plan template was not approved; DDA will consider this for future amendment, with stakeholder engagement. DDA clarified that providers must have written policies, train direct support staff on those policies on ensuring health and safety during the provision of virtual supports. DDA did not accept for funding allotted for providers to be used for obtaining, installing, implementing, or using virtual supports, such as equipment, internet, software applications, and other related expenses. Clarified that a participant does not need to revise their PCP if their BSP is updated. DDA clarified that recommendations for dedicated 1:1 and 2:1 support, enhanced supports, and overnight services need to be clearly identified in the BSP a participant does not need to revise their PCP if their BSP is updated, and that if a BSP takes longer than 6 months, enhanced, or dedicated supports will not be authorized. DDA did not remove language, "challenging behavior." DDA did not accept providing more than one BSP to a participant. DDA did not accept comments related to changing qualified provider requirements. DDA agreed to review its policies to ensure standardization with the waiver. DDA will engage with stakeholders on policies related to Behavioral Support Services being provided during Respite Care. Clarified that Behavioral Support Services can be provided at the same time as other direct supports. DDA did not accept comments related to removal of accessing funding pre-requisite before BSS waiver service. DDA clarified safeguards, as per COMAR 10.22.02 and 10.22.10. DDA will consider recommendation about limitations to services, hours per week.

Community Development Services (CDS)- DDA clarified the transportation is a component of Community Development Services, and not a standalone service. DDA also clarified that relatives may provide Community Development Services. DDA did not accept comments related to removing the requirement for providers to complete DDA application process or for offering CDS to retirees when they are not actively receiving CDS. Offering an enhanced CDS rate was not accepted. DDA will consider suggestions regarding concurrent billing with Employment Services-Discovery for a future amendment, with stakeholder engagement. DDA clarified that Community Development Services are authorized based on assessed needs.

Career Exploration (CE) - DDA did not accept comments related to being the payor of last resort or allowing Career Exploration at the same time as other services. Clarified that Career exploration is not a self-directed service option. Participants self-directing their services can access Employment Services. Clarified that Career Exploration supports all participants regardless of nursing care or personal care needs. Clarified comments related to qualified providers- community provides and entities that meet the provider qualifications can apply to be a Medicaid provider of this service. DDA clarified comments related to Community Integrated Employment Transition- 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.

Community Living-Group Home (CLGH) & Community Living-Enhanced Supports (CLES)- DDA did accept recommendation to remove the "awake and alert" overnight requirement. DDA did not accept provision of residential services to participants under 18, or that residential services may be provided to participants who self-direct.

**********PUBLIC INPUT SUMMARY CONTINUED AFTER THE TRANSITION PLAN IN ATTACHMENT 1 DUE TO SPACE LIMITATIONS**********

**********Continued from Appendix C - Employment Services- Service Definition due to SPACE LIMITATIONS.**********

K. Co-Worker Employment Supports are not intended to replace the support of the Employment Services provider's work, rather, it is an additional mentoring/support role for which coworkers could receive additional compensation above what they receive in the course of their typical job responsibilities. The payment of this compensation is at the discretion of the employer. Co-worker employment supports may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor, or other personnel.

L. The participant may exercise budget authority for all Employment Services: Discovery, Job Development, Ongoing Job Supports, Follow Along Supports, Self-Employment Development Supports, or Co-Worker Employment Supports.

M. If transportation is provided as part of this Medicaid waiver program service, then:

1. Except during Follow Along Supports, the participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service.

2. The Provider or participants self-directing their services must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

N. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program service; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the Maryland Board of Nursing; and

b. May not compromise the entirety of this Medicaid waiver program service

O. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

P. A participant's Person-Centered Plan may include a mix of employment and day services units such as Day Habilitation, Community Development Services, Co-Worker Supports, and Career Exploration provided at different times.

Q. Medicaid funds may not be used to defray the expenses associated with starting up or operating a business with the exception of the development of a business and marketing plan.

R. 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.

S. 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.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

T. Documentation must be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

U. A relative (who is not a spouse), legal guardian, or legally responsible person may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

V. Nursing Support Services, as applicable, can be provided during supports so long as it is not the primary or only service provided. The scope of the Nursing Support Services are defined under the stand-alone service in Appendix C.

W. In the event that additional Nursing Support Services Delegation training supports are needed, as indicated in the Health Risk Screening Tool because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by the DDA's Regional Office and additional standalone Nursing Support Services Delegation Service support service hours can be authorized.

X. Virtual Supports

1. Virtual supports is an electronic method of service delivery.

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including Health Insurance Portability and Accountability Act (HIPPA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH), and their applicable regulations to protect the privacy and security of the participant's protected health information.

3. Supports provided virtually support a participant to reach identified outcomes in their Person-Centered Plan.

4. Supports provided virtually may not be used for the provider's convenience.

5. This Medicaid waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Medicaid waiver program service.

7. Supports provided virtually cannot be used to assess a participant for a medical emergency.

8. 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.

9. MDH-licensed providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. 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.

Y. Employment Services are separate and distinct from residential services.

1. Participants may return home or to the provider operated site during time-limited periods of the day to participate in virtual supports as indicated in the participants file and service implementation plan.

2.Supports provided virtually can happen in the home or a licensed residential setting when the participant does not need paid direct support.

3. Residential and Personal Support Services cannot be billed during the times virtual supports are provided.

Z. For the Provider Managed Services delivery model:

1. 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.

2. 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.

3. 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 for (2) two consecutive plan years, may not be authorized these services for any subsequent plan year unless the participant secures employment.

4. For participants who are not currently authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports:

a. 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.

b. The Revised Person-Centered Plan should note that employment was secured and marked as an “urgent” plan.

AA. Anyone paid to provide a Medicaid waiver service, including participant’s employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

********Continued from Appendix C - Individual and Family Directed Goods and Services - Service Definition due to SPACE LIMITATIONS.***
F. The goods and services must provide or direct an exclusive benefit to the participant.

G. The goods and services provided must be cost-effective alternatives to standard Waiver or State Plan services (i.e., the service is not available from any other source, is least costly to the State, and reasonably meets the identified need).

H. The goods and services may not circumvent other restrictions on the claiming of Federal Financial Participation for Medicaid waiver program services, including the prohibition of claiming for the costs of room and board.

I. Reimbursement shall be reasonable, customary, and necessary, as determined for the participant’s needs, recommended by the team, and approved by the DDA or its designee. Reasonable and customary refers to prices or fees that are considered fair and typical for a service or product.

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

1. These efforts must be documented in the participant’s file.

2. If these services are deemed by the participant’s person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant’s needs shall be documented in the participant’s file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

4. If integrated programs or activities are available to the public, free, or at a lower cost they must be accessed first.

K. Day-to-Day Administrative Supports:
1. Day-to-Day Administrative Supports are available for participants:
a. Who are 18 years of age or older and currently unable to do these tasks independently;
b. The individual(s) that currently provide household management and medical appointment scheduling are not able to continue providing household management and medical appointment scheduling supports;
c. No additional natural supports are immediately available to provide household management and medical appointment scheduling support; and
d. Support is not available under other Medicaid or waiver services.

2. Day-to-Day Administrative Supports must:

a. Meet an outcome and be clearly documented in the participant's Person-Centered Plan;
b. Authorized by the DDA or its designee; and
c. Be linked to a team decision tree checklist for household management tasks and medical appointment scheduling needs included in the Person-Centered Plan. 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.

3. Support Broker Services are required when the participant employs any person to provide Day-to-Day Administrative Supports.

4. Individuals may not provide any other Medicaid waiver program service to the specific participant they are supporting with Day-to-Day Administrative Supports.

5. Support Brokers may not provide Support Broker Services and Day-to-Day Administrative Supports to the same participant.

6. 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). The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

L. Individual and Family Directed Goods and Services are not available to participants at the same time the participant is receiving support services in Shared Living services.

M. To the extent that any listed services are covered under the Medicaid State Plan, the services under the Medicaid waiver program would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

N. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the Financial Management and Counseling Services.

O. 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. Relatives can provide Day-to-Day Administrative Supports if they are not also a legal guardian or legally responsible person.

P. 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.

Q. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider,

subject to all laws and regulations associated with a Medicaid Provider.

**********CONTINUED FROM I-2-a DUE TO SPACE LIMITATIONS**********
Supported Living- The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program Support, Training, Transportation, and General & Administrative. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.

Tiered-Rate Service:

Shared Living Services- The three-tiered rates are based on the participant's level of need for supervision and monitoring or the need to mitigate behavioral risk or provide health and safety supports. Formerly a contract service, the tiered rates are based on historical budget amounts that include a stipend, case management, respite care and the application of 12% G&A.

Rates for Self-Directed Services

Individual and Family Directed Goods and Services and Support Broker Services are available for self-direction only and are negotiated market rates. Participants who are self-directing their services can also establish their own payment rates for approved services in their budgets as they are considered the employer; however, these rates must be reasonable and customary. To assist participants self-directing their services, the DDA posts reasonable and customary wages and rates in the Self-Directed Services Manual on the DDA website at https://health.maryland.gov/dda/Pages/sdforms.aspx.

Rate Adjustments

Since rates were initially published, there have been ongoing rate amendments. Prior to FY2016, rates were evaluated for a Cost-of-Living Adjustment (COLA). If a COLA was approved by the Maryland Legislature, the MDH Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget. Based on the budget allocations, rates may be funded at a percentage of the fully loaded Brick up to 100%. In addition, the geographical differential rates may also be funded at a percentage above the standard rates.

The Maryland General Assembly mandated 4% COLA was approved for the State FY2020 – FY2024. An additional 8% Cost-of-Living Adjustment was applied to FY2024 rates to be effective January 1, 2024, and a 3% Cost-of-Living Adjustment was added effective July 1, 2024. In Waiver Year 3, the budget includes geographical differential rates of 10% above the standard rate for eligible services.

In April 2021, the DDA increased the FPS rates in PCIS2 by 5.5% using savings from the American Rescue Plan Act of 2021 for all HCBS waiver services. The 5.5 % was calculated by applying 75% of American Rescue Plan Act of 2021 savings towards provider rates as directed by the State legislature.

In February 2022, the MDH started a new rate review process using the Rate Review Advisory Group (RRAG). The new Rate Review process is intended to ensure stakeholders understand the process by which rates are reviewed and feedback is collected, adhere to a structured timeline to support timely rate reviews, enable long-term development and maintenance of DDA rates, allow for stronger consistency in Medicaid rate setting processes, and demonstrate good stewardship of public funds.

Waiver provider rates are available on the DDA website, and service and rate changes are made through the regulatory process which includes publication in the Maryland Register, Medicaid Transmittal, and a 30-day public comment period as required by law. The last amendment to the rates occurred on or about July 1, 2022. The DDA will continue to review and amend rates as necessary based on the rate setting methodology for comparable services and based on actual costs at least every 3 to 5 years.

**********CONTINUED FROM APPENDIX E.1.a DUE TO SPACE LIMITATIONS**********
All duties for which the Support Broker will provide assistance should be noted on the Participant Agreement form and Service Implementation Plan.

Support Broker services are offered as an optional service to all participants who enroll in the Self-Directed Service Delivery Model, and as required service if the participant employs a relative, designated representative, legal guardian or Day-to-Day Administrative Support that is a paid provider. If a Support Broker is a participant's legal guardian, representative payee, or relative, there must be a policy in place that addresses conflict of interest and ensures oversight and integrity in the provision of

services. A participant's relative or legal guardian can only be a Support Broker for that person if they do not provide any other direct services, and there are no other relatives that provide direct services. A designated representative cannot be a participant's Support Broker.

Support Broker services may include the performance of activities that nominally overlap the provision of case management services. In general, such overlap does not constitute duplicate provision of services. For example, a Support Broker may assist a participant during the development of a Person-Centered Plan to ensure that the participant's needs and preferences are clearly understood even though a Coordinator of Community Services is responsible for the development of the service plan. Duplicate provision of services generally only arises when exactly the same activity is performed and billed on behalf of a waiver participant. Where the possibility of duplicate provision of services exists, the participant's Person-Centered Plan and record should clearly delineate responsibilities for the performance of activities.

Support Broker services can also assist participants to make their own decisions regarding human resources employer-related functions necessary for successful self-direction. This includes:

1. An initial introductory orientation related to the rights and responsibilities of the "employer of record", such as Department of Labor, and applicable federal, State and local employment requirements;

2. Development of staff policies, procedures, schedules, and backup plan strategies; and

3. Recruitment, advertising, and interviewing potential staff.

Individuals and organizations providing Support Broker Services may provide no other paid service to the participant they are providing Support Broker Services.

Financial Management and Counseling Services

1. The Financial Management and Counseling Services provider acts as a fiscal intermediary to assist the participant with employer and budget related accounting and payroll functions as per federal, State, and local laws, regulations, and policies necessary for successful self-direction. The Financial Management and Counseling Services provider assists the participant, along with their team, legal guardian, or designated representative (as applicable) in financial transactions and managing legal employment requirements and employer related functions including:

a. Verifying that potential employees, vendors, and DDA Medicaid providers meet applicable qualifications to render the services as set forth in this Medicaid waiver program application and applicable laws and regulations;

b. Facilitating the employment of staff by the participant;

c. Managing, tracking, and directing the disbursement of funds;

d. Processing payroll, withholding federal, State, and local tax and making tax payments to appropriate tax authorities;

e. Performing fiscal accounting processes; and

f. Making and sharing monthly expenditure reports with the participant, and their legally authorized representative (as applicable), Coordinator of Community Services, and State authorities.

(d) Other Relevant Information

1. In order to avoid conflicts of interest, a participant may not hire or select to provide services under a DDA-operated Medicaid waiver:

(a) An employee who is simultaneously employed by a targeted case management provider or otherwise provides targeted case management services; or

(b) A vendor or provider that simultaneously provides or has employees that provide targeted case management services.

Non-Disclosure Agreements

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.

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

The Developmental Disabilities Administration (DDA)

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

The MDH is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's Office of Long-Term Services and Supports (OLTSS) is the Medicaid unit within the SMA that oversees the Community Pathways Waiver. In this capacity, the OLTSS oversees the performance of the Developmental Disabilities Administration (DDA), which is the Operating State Agency (OSA) for the Waiver program. The OLTSS serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support provided by the DDA.

The DDA is responsible for the day-to-day operations of administering this Waiver program, including, but not limited to, facilitating the waiver application process to enroll into this Waiver program, reviewing and approving applications for potential providers, reviewing and monitoring claims for payment, and assuring participants receive quality care and services, based on the assurance requirements set forth in this waiver. The DDA is responsible for collecting, trending, prioritizing, and determining the need for system improvements.

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

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

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas:

1. Participant Waiver Application

The DDA certifies independent community-based organizations and local health departments to provide Coordination of Community Services to perform intake activities, including taking applications to participate in the Waiver program and referrals to county, local, State, and federal programs, and resources.

2. Support Intensity Scale (SIS)®

The DDA contracts with an independent community organization to conduct the Support Intensity Scale (SIS) ®. The SIS® is an assessment of a participant's needs to support independence. It focuses on the participant's current level of support needs, instead of focusing on skills or abilities they may not currently demonstrate. The Coordinators of Community Service use each completed SIS® as a planning guide in the development of the participant's Person-Centered Plan.

3. Quality Assurance

The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys.

4. System Training

The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (e.g., person-center planning), health and welfare (e.g., choking prevention), and workforce development (e.g., alternative communication methods).

5. Research and Analysis

The DDA contracts with independent community organizations and higher education entities for research and analysis of the Medicaid waiver program's service data, trends, options to support the Medicaid waiver program assurances, financial strategies, and rates.

6. Financial Management and Counseling Services

The DDA contracts with independent community organizations for Financial Management and Counseling Services to support participants that are enrolled in the DDA's SDS Model, as described in Appendix E.

7. Health Risk Screen Tool

The DDA contracts with IntellectAbility for training and the use of an electronic Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs and training.

8. LTSSMaryland - Long Term Services and Supports Information System

The MDH contracts with information technology organizations for design, revisions, and support of the electronic software database that supports the Waiver program's administration and operations.

9. Behavioral and Mental Health Crisis Supports

The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during a participant's behavioral and mental health crisis.

10. Organized Health Care Delivery System providers

Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community-based individuals and entities that are not Medicaid providers. The OHCDS provider's administrative services to support this action is not charged to the participant.

11. Provider Search Directory

The DDA contracts with an agency to develop a web-based provider searchable database of its licenses service providers by service location and type. The end user can search providers by typing the name of the provider, selecting a county, selecting a waiver type and service or a combination of county/waiver type/service.

12. Person Centered Planning, Training, and System Enhancement

The DDA contracts with LifeCourse Nexus Training and Technical Assistance Center from UMKC to assist with the enhancement of the Person-centered process to gather input from stakeholders in making our process meaningful for the participant and their families.

13. Positive Behavioral Supports Implementation, Training, and Capacity Building

The DDA contracts with the Institute on Community Integration (ICI) at the University of Minnesota including (1) building capacity to transfer expertise in the implementation of Positive Behavior Support; and (2) expanding training for professional development and competency-based training of direct support professionals.

14. Self-Direction Information, Technical Assistance and Support

The DDA contracts with Applied Self Direction for information, technical assistance and support related to national policies and requirements; discussion forums on best practices; topic consultation; and projects.

15. Change Management

To promote the effective implementation of key change initiatives, the DDA contracts with change management consultants to support the diagnosis, design, assessment, and delivery of change strategies and stakeholder engagement.

15. Quality Improvement Organization (QIO)

The DDA contracts with a certified QIO or QIO–like organization to support administrative functions related to technical assistance, quality assurance, and utilization review.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

The MDH, including the OLTSS, and the DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

Appendix A: Waiver Administration and Operation

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

The MDH in general, and the DDA individually, each have a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which they enter.

In accordance with the State's applicable procurement laws, a contract monitor is assigned to provide technical oversight for each agreement, including specific administration and operational functions supporting the Waiver program as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

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

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

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

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

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

5. Research and Analysis – DDA staff review activity reports and supporting documentation upon receipt prior to approval of invoices.

6. Financial Management and Counseling Services (FMCS) – MDH's FMCS Program Manager oversees contract requirements. The QIO conducts audits of FMCS records for compliance with operational tasks annually and provides technical assistance, training, or request corrective action as needed.

7. HRST – DDA's contract monitor reviews submitted invoices and documentation related to completed HRSTs upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies. QIO conducts quality reviews.

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

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

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

11. OHCDS providers - QIO audits service providers for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

12. Provider Search Directory - DDA staff review activity reports and supporting documentation upon receipt prior to approval of invoices.

13. Person Centered Planning, Training, and System Enhancement - DDA staff review invoice and supporting documentation upon receipt prior to approval of invoices.

14. Positive Behavioral Supports Implementation, Training, and Capacity Building - DDA staff review invoices and supporting documentation upon receipt prior to approval of invoices.

15. Self-Direction Information, Technical Assistance and Support - DDA staff review invoices and supporting

documentation upon receipt prior to approval of invoices.

16. Change Management – DDA staff review invoices and supporting documentation upon receipt prior to approval of invoices.

17. QIO – DDA QIO Program Manager oversees contract requirement and review invoices and supporting documentation upon receipt prior to approval of invoices.

The DDA and OLTSS meet monthly and discuss any issues that may require additional guidance.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
AA - PM1: # and % of annual Quality Reports submitted by the DDA, to the OLTSS, in the correct format and timely. N = # of Quality Reports submitted by the DDA in the correct format and timely. D = # of Quality Reports required by the OLTSS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA Quality Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA - PM2: # and % of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D = # of providers.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA - PM3: # and % of waiver manuals approved by the Office of Long-Term Services and Supports. N = Number of waiver manuals approved by the Office of Long-Term Services and Supports. D = Total number of waiver manuals issued.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Presentation of manuals or procedures

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA - PM4: # and % of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meeting scheduled that focused on monitoring of performance measures during the fiscal year.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA-PM5:#/% of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. N=# of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. D = # of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed by the OLTSS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCIS2 PORII Module

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA - PM6: # and % of on-site death investigations conducted by the OHCQ and reviewed by the OLTSS that met requirements. N = # of OHCQ on-site death investigations reviewed by the OLTSS that met requirements. D = # of OHCQ on-site death investigations reviewed by the OLTSS.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The MDH's Office of Long-Term Services and Supports (OLTSS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned operational and administrative functions in accordance with the Waiver program's requirements. To this end, the OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to the OLTSS. It is a report on the status of the Waiver program's performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care (LOC), Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administrative Authority. The report includes any barriers to data collection and remediation steps.

The OLTSS, upon review of the report, will meet with the DDA to address challenges and barriers. Guidance from the OLTSS to the DDA regarding changes in policies, procedures, or other system changes will be dependent upon the challenges or barriers identified. The OLTSS and the DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, The OLTSS and the DDA develop solutions guided by waiver assurances and the needs of waiver participants with the OLTSS exercising ultimate authority to approve such solutions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	0		☒

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

To be eligible for participation in this Medicaid Home and Community-Based Services (HCBS) Waiver program, an individual shall:

1. Have a developmental disability, as defined in § 7-101 of the Health-General Article of the Maryland Annotated Code, which is comparable to the federal definition found at 45 C.F.R. § 1325.3;

2. Meet the LOC provided by an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), as further described in Appendix B-6, below;

3. Meet financial eligibility requirements as set forth in this Appendix B; and

4. Meet technical eligibility requirements set forth below.

To be eligible for participation in the Medicaid waiver program, an applicant or participant must meet all of the following technical eligibility requirements:

1. The individual is a resident of the State of Maryland. This includes consideration of whether the individual meets special criteria for military families set forth in Title 7 of the Health-General Article of the Maryland Annotated Code.

2. The individual is not enrolled simultaneously as a participant in another Medicaid Home and Community-Based Services Medicaid waiver program, under the authority of Section 1915(c) of the Social Security Act or PACE, a Maryland Medicaid capitated managed care program that includes long-term care.

3. The individual does not currently reside in an institution for 30 consecutive calendar days or has a proposed date for discharge from the institution in which the individual does reside.

4. The Medicaid waiver program’s services are the most appropriate and cost-effective means to meet the individual’s needs without jeopardizing the health, safety, or welfare of the individual or others, including, but not limited to:

a. The individual needs services and supports when school is not in session, if the individual attends school;

b. The individual requests services that are covered by and, therefore, may be funded by the Medicaid waiver program; and

c. In combination with available natural supports, community supports, and services funded by other programs, the individual’s needs can be met by the Medicaid waiver program’s services such that the individual’s health, safety, and welfare can be maintained in the community.

5. The individual complies with applicable Medicaid waiver program requirements as set forth in this Medicaid waiver program application, applicable federal and State law and regulations, and Department or DDA policies including:

Participants who are still eligible to receive services through the IDEA shall have a portion of their daily support and supervision needs covered by the school system. The Medicaid waiver program does not provide services during school hours to avoid duplication with services required under IDEA; and

6. The individual must meet the eligibility criteria for waiver participation as outlined in the Medicaid waiver application and in accordance with Code of Maryland Regulations 10.22.12.11, and 10.09.24.04-1C.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (◉) **Not applicable. There is no maximum age limit**
- (○) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	16365
Year 2	16498
Year 3	20573
Year 4	20710
Year 5	21446

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Court Involvement	
Deinstitutionalization	
Transitioning Youth	
Previous Waiver Participants with New Service Need	
End the Wait Act 2022	
Crisis Resolution	
Department of Human Services (DHS) Foster Kids Age Out	
Community Support Participants with Increased Need	
Psychiatric Hospital Discharge	
Waiting List Equity Fund	
Military Families	
Families with Multiple Children on Waiting List	
Emergency	
Family Support Participants with Increased Need	
State Funded Conversions	
Money Follows the Person	
Maryland State Department of Education (MSDE) Residential Age Out	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Court Involvement

Purpose *(describe):*

The purpose of reserved capacity is to provide community services to individuals identified through the Maryland court system.

Describe how the amount of reserved capacity was determined:

Current data show an increase in court involvement related individuals. The capacity has been increased by 5.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Deinstitutionalization

Purpose *(describe):*

Deinstitutionalization

Purpose: The purpose of this reserved capacity category is to support individuals with developmental disabilities that transition from a State Residential Center or Nursing Facility to DDA services not covered under the federal Money Follows the Person.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on the number of requests received for individuals who are transitioning from State Residential Center or Nursing Facility to DDA services over the past year.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitioning Youth

Purpose *(describe):*

Individuals transitioning from educational services including public school system and nonpublic school placements. The purpose is to transition the most vulnerable youth from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on students transitioning and projection of individuals that may need residential services.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150

Waiver Year	Capacity Reserved
Year 3	850
Year 4	850
Year 5	850

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Previous Waiver Participants with New Service Need

Purpose *(describe):*

Previously enrolled DDA waiver participants for whom the waiver service needs were met will exit the waiver. If a new service need develops at a later time, they may reapply to the waiver. There is no limit on the time period that a participant exited the Waiver in order for them to reapply. If a person was previously enrolled in the waiver, had their needs met, and then developed a new need for services, they can reapply to the waiver.

Describe how the amount of reserved capacity was determined:

Based on historical data, this number has stayed consistently below the projected total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

End the Wait Act 2022

Purpose *(describe):*

The purpose of this reserved capacity category is to support individuals currently on the waiting list to access Waiver Services, in accordance with the End the Wait Act of 2022 (HB 1040). The law requires the Department to develop plans to reduce the DDA waitlist by 50% beginning in fiscal year 2024.

MDH - Waiver Programs - Waitlist and Registry Reduction (End the Wait Act) was passed by the Maryland General Assembly. It was approved by the Governor on May 16, 2022 and took effect October 1, 2022. MDH submitted plans to the Governor and required legislative committee chairs. Reference: SB 636 (Chapter 464 of the Acts of 2022) - Waiver

Programs - Waitlist and Registry Reduction (End the Wait Act)

The DDA's waitlist average includes approximately 4,000 individuals as of November 2022. To reduce the waitlist for the DDA-operated Medicaid waiver programs by 50%, the DDA will need to enroll 2,000 participants from the waitlist to the Medicaid waiver program over a five year period. This will result in enrollment of 400 participants annually across all three programs.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on projections for cutting the waitlist in half over the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	75
Year 2	75
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Crisis Resolution

Purpose *(describe):*

The purpose of this reserved capacity category is to support individuals identified to be in the crisis resolution eligibility category who are in immediate need of services, to access needed services.

People that meet this category have been determined to meet one of the following criteria:

1. Homelessness or housing that is explicitly time-limited, with no viable non-DDA-funded alternative;
2. At serious risk of physical harm in the current environment;
3. At serious risk of causing physical harm to others in the current environment; or
4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and trend over time. The number of people identified for crisis resolution eligibility category has increased over time. Based on this we have projected the following slots needed for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100

Waiver Year	Capacity Reserved
Year 3	275
Year 4	275
Year 5	275

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Department of Human Services (DHS) Foster Kids Age Out

Purpose *(describe):*

Individuals within the DHS foster care system receive foster care residential supports up to the age of 18 years. At age 18, they must transition from their foster care home to other residential services and supports. The purpose of this reserved category is to transition these individuals from DHS's foster care residential supports while they continue to receive State educational services until age 21 as per State regulation.

Describe how the amount of reserved capacity was determined:

Initial reserved capacity is based on historical data on individuals from the foster care system who need residential supports.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Community Support Participants with Increased Need

Purpose *(describe):*

Community Supports Waiver Participant with ongoing increased needs that cannot be met within the waiver.

Describe how the amount of reserved capacity was determined:

Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Psychiatric Hospital Discharge

Purpose *(describe):*

Individuals with developmental disabilities that transition from inpatient mental health facilities need community supports and services. Transitions from an inpatient mental health facility are not covered under the federal Money Follows the Person grant. The State has identified this group as a priority and therefore is establishing reserved capacity.

Describe how the amount of reserved capacity was determined:

Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Waiting List Equity Fund

Purpose *(describe):*

As per Maryland Statute, Health General Article 7-205, the Waiting List Equity Fund is to support people who are in crisis and need emergency services, individuals on the waiting list, and individuals transitioning from a State Residential Center. This category supports people transitioning from State residential centers and people on the Waiting List with the eldest

caregiver.

Describe how the amount of reserved capacity was determined:

Reserved capacity is determined based on historical data and equity achieved through transitions of people leaving a State Residential Center as approved by the Maryland General Assembly.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Military Families

Purpose *(describe):*

Military Families category is based on legislation (Senate Bill 563) passed during the Fiscal Year 2015 session to support individuals' reentry into services after returning to the State. It is also available to support military families who move to Maryland, once they obtain residency. The U.S. Department of Defense has provided information and fact sheets related to eligibility requirements and lengthy waiting lists hindering military families from obtaining supports and services for members with special needs during critical transition periods. There are national efforts to allow service members to retain their priority for receiving home and community-based services.

Describe how the amount of reserved capacity was determined:

Initial estimate assumes 10 families on the DDA Waiting List will need services. Based on historical data, this slot category has not been used. Thus, it is safe to assume it would not exceed the reserved capacity for year 1 in the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Families with Multiple Children on Waiting List

Purpose *(describe):*

The purpose of this reserved capacity category is to support families seeking supports that have more than one child on the DDA Waiting List. Families may have more than one child on the waiting list that applied at different times. The children may also have different waiting list priority categories (i.e. crisis resolution, crisis prevention, or current request). This category supports the needs and stability of the entire family by providing all children on the waiting list, regardless of application date or priority category, an opportunity to apply for the waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate is based on the number of families with more than one child on the DDA Waiting List or Future Needs Registry.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergency

Purpose *(describe):*

The purpose of this reserved capacity category is to support individuals who are not on the waiting list and are unknown to the DDA, and who are in immediate crisis or other situations that threaten the life and safety of the person.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and Maryland's General Assembly approval.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50

Waiver Year	Capacity Reserved
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Family Support Participants with Increased Need

Purpose *(describe):*

Family Supports Waiver Participant with ongoing increased needs that cannot be met within the waiver.

Describe how the amount of reserved capacity was determined:

Based on historical data, reserved slot use for this category increased over time however, not above the projected total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

State Funded Conversions

Purpose *(describe):*

State Funded Conversions refers to individuals receiving ongoing services funded with 100 percent State general funds including previous years that participants failed to maintain their Medicaid waiver program eligibility and were disenrolled. Some individuals may leave the waiver for various reasons such as entering a hospital or rehabilitation facility to meet their needs at that time or failure to complete the financial redetermination process. The State has supported these individuals with 100 percent State General Funds for services instead of placing them on a waiting list if they do not meet any of the reserved capacity priority categories. By establishing this priority category, the State can provide additional waiver services to meet needs and maximize State General Funds to support additional individuals in the waiver.

Describe how the amount of reserved capacity was determined:

Current data reflects over 600 individuals receiving State Funding that may be Medicaid waiver eligible. Therefore, we have increased the proposed capacity to support enrollment.

Current data indicates that over 600 individuals receiving State Funding meet the Developmentally Disabled criteria. In alignment with Governor Wes Moore's government modernization initiative aimed at promoting smarter, more effective operations and saving taxpayer money, the Developmental Disabilities Administration is prioritizing the enrollment of all State-Funded DD-eligible participants into the Medicaid waiver program. We anticipate that 394 additional individuals will complete the enrollment process within the current fiscal year which will take our current reserved slots to 600, with the remaining 300 individuals expected to finalize their enrollment in the next fiscal year. We do not anticipate additional individuals to transition out of State Funded Services

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	200
Year 2	206
Year 3	300
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person

Purpose *(describe):*

As per Maryland Statute, Health General Article 15–137, reserved waiver capacity is for eligible individuals moving out of institutions under the Money Follows the Individual Accountability Act.

Describe how the amount of reserved capacity was determined:

Estimate based on transitions under the Money Follows the Person federal grant. Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	45
Year 4	45
Year 5	45

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Maryland State Department of Education (MSDE) Residential Age Out

Purpose *(describe):*

Children supported by the MSDE residential services may be placed either in or out of the State of Maryland for residential support based on assessed service need. The purpose of this reserved category is to transition these individuals from the MSDE residential supports while they continue to receive State educational services until age 21 as per State regulation. These are individuals who are aging out of residential services under the MSDE. They are not in the Department of Human Services (DHS) foster care system.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on individuals that transition from the MSDE residential supports while they continue to receive State educational services.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are prioritized for entrance to the waiver based on: (1) reserved capacity categories described in subsection c. above; and (2) the Waiting List priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12.

Reserved Capacity

In addition, reserved capacity is established for discrete groups of individuals as noted in subsection c above 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.

Waiting List

The DDA prioritizes individuals' placement on the Waiting List into one of three categories based on each individual's needs: (1) Crisis Resolution; (2) Crisis Prevention; and (3) Current Request.

Crisis Resolution - To qualify for this category, the applicant must meet one or more of the following criteria.

1. Homeless or living in temporary housing with clear time-limited ability to continue to live in this setting with no viable non-DDA funded alternative;

2. At serious risk of physical harm in the current environment;

3. At serious risk of causing physical harm to others in the current environment; or

4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Crisis Prevention - To qualify for this category, the applicant:

1. Shall have been determined by the DDA to have an urgent need for services;

2. May not qualify for services based on the criteria for Category I– Crisis Resolution; and

3. Shall be at substantial risk for meeting one or more of the criteria for Crisis Resolution within 1 year, or have a caregiver who is 65 years old or more.

Current Request - To qualify for this category, the applicant shall indicate at least a current need for services.

When funding becomes available, individuals in the highest priority level of need (Crisis Resolution) receive services, followed by Crisis Prevention, and then Current Request. Determination of and criteria for each service priority category is standardized across the State as set forth in DDA's regulations and policy.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [x] **Pregnant Women (42 CFR § 435.116)**
- [x] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR § 435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

Individuals aged 19 up to 65 (42 CFR 435.119)
Reasonable classifications of individuals under 21 (42 CFR 435.222)
Optional targeted low-income children (42 CFR 435.229)
Foster care children under IV-E (42 Code of Federal Regulations 435.145)
Independent foster care adolescents (42 Code of Federal Regulations 435.226)
Children in state-subsidized adoption (42 Code of Federal Regulations 435.227)

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☒ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**

(*select one*):

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ◉ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

183 calendar days

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

LOC evaluations and re-evaluations are performed by each Coordinator of Community Services (CCS) with review and approval by the DDA.

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Each CCS must meet the established provider qualifications for TCM under the Medicaid State Plan and Appendix D-1.a. of this waiver.

Each CCS is required to participate in in-service training on assessment and evaluation, LOC determination, and waiver eligibility. The CCS is responsible for gathering information, including medical, psychological, and educational assessments, as part of the LOC determination process. The CCS must be able to critically review assessments in order to make a recommendation to DDA regarding LOC.

Final decisions regarding LOC are made by the DDA.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All waiver participants must meet the DDA's criteria for developmental disability in accordance with Annotated Code of Maryland, Health-General Article, § 7-101, which is comparable to the federal definition found at 45 Code of Federal Regulations § 1325.3.

In order to be eligible for the Waiver, applicants must also meet the LOC criteria for an ICF/IID. See 42 U.S.C. § 1396n(c); 42 CFR §441.301(b)(1)(iii). Therefore, DDA considers the LOC of an ICF/IID in its application of its statutory definition of developmental disability. In determining the LOC for an ICF/IID, the DDA looks to the federal definitions of intellectual disability and related conditions, set forth in 42 CFR §435.1010, as required for admission to an ICF/IID. See 42 CFR §440.150(a)(2).

The DDA requires that the CCS completes a Comprehensive Assessment (CA) form based on these criteria. The CCS uses the CA to make an informed recommendation to the DDA on eligibility for all individuals who apply for services. The CCS submits the CA as well as any supporting documentation the CCS has gathered, including professional assessments and standardized tools via LTSSMaryland for review. The CCS verifies annually that the participant continues to meet the developmental disability eligibility determination.

In emergency situations, the DDA may complete the CA to determine the eligibility.

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the

evaluation process, describe the differences:

Each CCS completes the initial LOC evaluation and annual reviews.

Initial Evaluation

As described in subsection d. above, for the initial evaluation, the CCS completes the CA and submits via LTSSMaryland, including any supporting documentation. Supporting documentation may include professional assessments such as psychological, neuropsychological, and medical evaluations, special education evaluations, behavioral rating scales, autism rating scales, evaluations conducted by speech-language, physical, and occupational therapists, and social histories.

The DDA Regional Office staff review these materials and the DDA Regional Director issues a final determination on eligibility.

In emergency situations, the DDA may complete the CA to determine the eligibility.

Annual Re-Evaluation

The CCS reviews a participant's LOC eligibility on an annual basis, assessing whether there are any changes in status and completes the LOC recertification form. The DDA ensures review of all participants on an annual basis. If there are changes in a participant's status, then the CCS submits a request for a reconsideration with any new supporting documentation, to the DDA Regional Office for review via LTSSMaryland.

If a participant no longer meets LOC or other eligibility requirements, the DDA will disenroll the participant from the Medicaid waiver program.

Failure to Meet LOC Requirement

If an applicant or current participant is denied eligibility for an enrollment in the waiver then they are provided a Medicaid Fair Hearing, as further specified in Appendix F.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

LTSSMaryland provides alerts and generates reports related to status of annual LOC re-evaluations, therefore ensuring that all enrolled waiver participants obtain an annual re-evaluation of their LOC. The Quarterly Level of Care Report includes data to reflect LOCs due in 90 days, 60 days, 30 days, and overdue by CCS agency.

The CCS completes the re-evaluation as provided in subsection f. above. The CCS completes a recertification of need form and uploads into the LOC module in LTSSMaryland.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Information is located in the State's information technology system - LTSSMaryland.

"LTSSMaryland" is a customized, integrated care management tracking system that manages real-time medical and service information regarding Medicaid participants.

Information is retained in LTSSMaryland under the Programs > LOC module.
The LTSSMaryland system currently maintains the full history of documents.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC – PM1 - Number and percentage of applicants who have an initial level of care completed. Numerator = number of applicants who have an initial level of care completed. Denominator = number of new applicants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Quality Improvement Organization (QIO) Targeted Case Management Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
QIO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
n/a

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		m/a
☒ **Other** Specify: n/a	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: n/a	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: n/a

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC – PM2 - Number and percentage of applicants that have an initial level of care that meets Appendix B-6 Level of Care criteria and procedure standards. Numerator = number of applicants that have an initial level of care that meets Appendix B-6 Level of Care criteria and procedure standards. Denominator = number of applicants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization (QIO) Targeted Case Management Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DDA’s Coordination of Community Services staff provides technical assistance and support on an ongoing basis to CCS providers and will provide specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used including additional communications, and training to providers. The DDA will document its remediation efforts in the provider’s file.

The Quality Improvement Organization conducts Targeted Case Management Reviews and analyzes information regarding individual and systemic deficiencies. The Quality Improvement Organization shares findings with DDA and provides recommendations on rememediation and overall quality enhancement. DDA considers recommendations and has made updates to improve policies, waiver proposals, including improving performance measures based on this data.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each individual and participant is afforded Freedom of Choice in their:

1. Selection of institutional or community-based care;
2. Selection of service delivery model (either SDS or Traditional Services Models); and
3. Ability to choose from qualified providers (i.e., individuals, community-based services providers, vendors, and entities) based on service delivery model.

After an individual is determined to be eligible for the waiver, but prior to determining need for specific services or entering services, the CCS informs the individual and their authorized representative (if any) of services available under both an ICF/IID or other institutional setting and DDA's Home and Community-Based Medicaid waiver program. The CCS also provides information regarding service delivery models available under the DDA's Medicaid waiver program. In addition, for those individuals considering the waiver, the CCS provides the individual and their authorized representative with information on how to access via the internet, a comprehensive listing of DDA services and providers. If the applicant or their legal representative does not have internet access, the CCS will provide a hard-copy resource manual.

Then, the individual and their authorized representative are given the choice of receiving services in either an institutional setting or home and community-based setting. This choice must be documented in the DDA's "Freedom of Choice" Form. The CCS presents and explains this form to the individual and their authorized representative and family. This form is available to CMS upon request.

The application packet is not considered complete and the individual will not be enrolled in the waiver until the Freedom of Choice form is signed by the individual or their authorized representative, and the CCS.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

LTSSMaryland retains copies of the "Freedom of Choice" form.
Information is retained in LTSSMaryland under the Programs > Application > DDA Waiver Application Packet module.
The LTSSMaryland system currently maintains the full history of documents.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

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. All agency staff receive training in cultural competence as it relates to health care information and interpreting services.

The MDH's website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community.

The State also provides translation services at Medicaid Fair Hearings, if necessary. If an LEP 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.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case*

management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Career Exploration
Statutory Service	Community Living - Group Home
Statutory Service	Day Habilitation
Statutory Service	Live-in Caregiver Supports
Statutory Service	Medical Day Care
Statutory Service	Personal Supports
Statutory Service	Respite Care Services
Statutory Service	Supported Employment (phased out effective years 3, 4, and 5)
Other Service	Assistive Technology and Services
Other Service	Behavioral Support Services
Other Service	Community Development Services
Other Service	Community Living - Enhanced Supports
Other Service	Employment Discovery and Customization (phased out effective years 3, 4, and 5)
Other Service	Employment Services
Other Service	Environmental Assessment
Other Service	Environmental Modifications
Other Service	Family and Peer Mentoring Supports
Other Service	Family Caregiver Training and Empowerment Services
Other Service	Housing Support Services
Other Service	Individual and Family Directed Goods and Services
Other Service	Nursing Support Services
Other Service	Participant Education, Training, and Advocacy Supports
Other Service	Remote Support Services
Other Service	Shared Living
Other Service	Support Broker Services
Other Service	Supported Living
Other Service	Transition Services
Other Service	Transportation
Other Service	Vehicle Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Career Exploration

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

A. Career Exploration are time limited services to help participants learn skills to work toward competitive integrated employment.

1. Teaching methods based on recognized best practices are used such as systematic instruction.

2. Career Exploration provides the participant with opportunities to develop skills related to work in a competitive employment position in an integrated community environment including learning:

a. Skills for employment, such as time-management and strategies for completing work tasks;

b. Socially acceptable behavior in a work environment;

c. Effective communication in a work environment; and

d. Problem-solving for a work task.

B. Career Exploration includes: (1) Facility-Based Supports; (2) Small Group Supports; and (3) Large Group Supports.

1. Facility-Based Supports can be at a fixed site that is owned, operated, or controlled by a licensed provider or an off-site location. It also includes doing work under a contract being paid by a licensed provider.

2. Small Group Supports are provided in groups of between 2 and 8 individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. Small Group Supports models include enclaves, mobile work crews, and work tasks on a contract-basis. The licensed provider is the employer of record and enters into the contract on behalf of the group.

3. Large Group Supports are provided in groups of between 9 and 16 individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. The licensed provider is the employer of record and enters into the contract on behalf of the group.

C. Career Exploration services include:

1. Direct support services that enable the participant to learn skills to work toward competitive integrated employment, as described in Sections A-B above;

2. The following services provided in combination with, and incidental to, the provision of this Waiver program service:

a. Transportation to and from and within this Medicaid waiver program service;

b. Delegated nursing tasks or other nursing support services covered by this Medicaid waiver program based on assessed

need; and

c. Personal care assistance, based on the participant's assessed need.

d. Nursing Support Services based on assessed need. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary school.

B. Career Exploration services must be provided in compliance with all applicable federal, State, and local laws and regulations.

C. Participants must have an employment goal within their PCP that outlines how they will transition to community integrated employment (such as participating in discovery and job development) or another service.

D. The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's assessed level of service need.

E. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The provider must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's PCP; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation;

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

F. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program service;

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the Maryland Board of Nursing (MBON); and

b. May not compromise the entirety of this Medicaid waiver program service.

G. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

H. A participant's PCP may include a mix of employment and meaningful day type services such as Day Habilitation, Community Development Services, and Employment Services provided at different times under both service delivery models.

I. 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.

J. 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, MSDE, DORS, DHS, and any other federal

or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

K. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community-based services and avoiding institutionalization.

L. Nursing Support Services, as applicable, can be provided during services so long as it is not the primary or only service provided. The scope of the Nursing Support Services are defined under the stand-alone service in Appendix C.

M. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA's Regional Office and additional standalone Nursing Support Services hours can be authorized.

N. 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.

O. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Career Exploration may not exceed a maximum of 8 hours per day or 40 hours per week including in combination with any of the following other Medicaid waiver program services in a single day: Community Development Services, Employment Service – Job Development, and Day Habilitation services.

2. Career Exploration services for participants accessing this service for the first time is limited to up to 720 hours for the plan year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Career Exploration Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Career Exploration

Provider Category:

Agency

Provider Type:

Career Exploration Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability employment services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Career Exploration;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

N. Be licensed by the OHCQ;

O. All providers must meet and comply with the federal community settings regulations and requirements;

P. Have a signed Medicaid Provider Agreement;

Q. Have documentation that all vehicles used in the provision of services have automobile insurance; and

R. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for a 3 year period unless otherwise noted in the approval letter.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have DDA required credentials, license, or certification;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

4. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

6. Complete necessary pre/in-service training based on the PCP;

7. Satisfactorily complete required orientation and training designated by DDA;

8. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified providers.

2. Provider for verification of individual staff members’ licenses, certifications, and training.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Community Living - Group Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Community Living Group Home services provide the participant with development, acquisition, and maintenance of skills related to activities of daily living, instrumental activities of daily living, and socialization, through application of formal teaching methods in a community residential setting.

B. Skills to be developed, acquired, or maintained under this service will be determined based on the participant's individualized goals and outcomes as documented in the participant's file.

C. Formal teaching methods are used such as systematic instruction.

D. This service will provide the participant with opportunities to develop skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization including:

1. Learning socially acceptable behavior;

2. Learning effective communication;

3. Learning self-direction and problem solving;

4. Engaging in safety practices;

5. Performing household chores in a safe and effective manner;

6. Performing self-care; and

7. Learning skills for employment.

E. This service includes Nursing Support Services based on assessed need. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.

F. Community Living - Group Home services include coordination, training, supports, or supervision (as indicated in the PCP) related to development and maintenance of the participant's skills.

G. This Medicaid waiver program service includes provision of:

1. Direct support services, for provision of services as provided in Sections A-B above; and

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation to and from and within this Medicaid waiver program service;

b. Delegated nursing tasks or other Nursing Support Services covered by this Medicaid waiver program, based on the participant's assessed need; and

c. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older.

B. Participants must be preauthorized by the DDA based on documented level of supports needed.

C. 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.

D. The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's level of service need.

1. Based on the participant's assessed needs, the DDA may authorize dedicated hours for 1:1 and 2:1 staff-to-participant supports.

2. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participant ratio:

a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio 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 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.

d. 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.

2. Dedicated hours can be used to support more than one participant if it meets their assessed needs and the following requirements are met:

a. The participants are retired, transitioning from one meaningful day service to another, recovering from a health condition, or receives less than 40 hours of meaningful day services;

b. Support is documented in each participant's PCP and provider's service implementation plan; and

c. Dedicated hours are billed for only one participant.

B. The following criteria will be used to determine if the participant has an assessed need for Community Living – Group Home services:

1. Participant has critical support needs that cannot be met by other residential or in-home services and supports;

2. This residential model is the most integrated and most cost-effective service to meet the participant's needs; and

3. The participant meets one of the following criteria:

a. They currently live on their own and are unable to care for themselves even with services and supports;

b. They currently live on their own or with family or other unpaid caregivers and such living situation presents an imminent risk to their physical or mental health and safety or the health and safety of others;

c. The participant is (i) homeless and living on the street; (ii) has no permanent place to live; or (iii) at immediate risk of homelessness or having no permanent place to live;

d. The participant currently lives with family or other unpaid caregivers and documentation exists that in-home services available through the other waiver services would not be sufficient to meet the needs of the participant;

e. The participant's family's or unpaid caregiver's health changes significantly where the primary caregiver is incapacitated and there is no other available caregiver. Examples of such significant health changes include a long-term illness or permanent injury;

f. There is no family or unpaid caretaker to provide needed care;

g. There is a risk of abuse or neglect to the participant in their current living situation as evidenced by: (1) recurrent involvement of the Child Protective Services (CPS) or Adult Protective Services (APS) as documented by the case manager that indicates the participant's health and safety cannot be assured and attempts to resolve the situation are not effective with CPS or APS involvement or (2) removal from the home by CPS or APS;

h. With no other home or residential setting available, the participant is: (i) ready for discharge from a hospital, nursing facility, State Residential Center, psychiatric facility, or other institution; (ii) ready for release from incarceration; (iii) residing in a temporary setting such as a shelter, hotel, or hospital emergency department (iv) transitioning from a residential school; or (v) returning from an out of State placement; or

i. Extenuating circumstances.

C. Under this Medicaid waiver program service, the participant's primary residence must meet the following requirements:

1. This Medicaid waiver program service must be provided in a group home setting, owned or operated by the provider.

2. No more than four participants may receive this Medicaid waiver program service in a single residence, unless previously approved by the DDA.

3. 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 CFR § 441.301(c)(4) as amended: and

4. Each participant receiving this Medicaid waiver program service must be provided with a private, single occupancy bedroom unless two participants choose each other as roommates because they prefer to share a room, or they are married or otherwise in a relationship and choose to share a bedroom.

D. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver

program service;

2. The Provider must:

a. Provide, or arrange for provision of transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

E. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Medicaid waiver program service.

F. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

G. The provider must have an organizational structure that ensures services are available at each licensed site on a 24-hour, 7-day a week basis, including back-up and emergency support, in accordance with staffing requirements set forth in each participant's file.

H. Community Living – Group Home trial experience for people transitioning from an institutional or non-residential site on a temporary, trial basis.

1. Service must be preauthorized by the DDA.

2. Services may be provided for a maximum of 7 days or overnight stays within the 180-day period in advance of their move.

3. When services are furnished to participants returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver.

4. The individual must be reasonably expected to be eligible for and to enroll in the waiver. Services are billed to Medicaid as an administrative cost.

I. A Residential Retainer Fee is available for up to 18 days per calendar year, per recipient, when the recipient is unable to receive services due to hospitalization, behavioral respite, or family/friend visits.

J. Community Living – Group Home services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.

K. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA's Regional Office and additional standalone Nursing Support Services hours can be authorized.

L. The Medicaid payment for Community Living – Group Home service may not include either of the following items which the provider is expected to collect from the participant:

1. Room and board; or

2. Any assessed amount of contribution by the participant for the cost of care.

M. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS*******

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SERVICE DEFINITION CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS*******

N. 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, MSDE, DORS, DHS, and any other federal or State government funding program, must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

O. Community Living—Group Home services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Day Habilitation, Employment Services, Medical Day Care, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

P. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community-based services and avoiding institutionalization.

Q. 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.

R. Direct Support Professional services may be provided in an acute care hospital for the purposes of supporting the participant's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary waiver services:

a. Must be identified in the individual's file;

b. Must be provided to meet the individual's needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserve the participant's functional abilities.

S. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

****

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Community Living – Group Home Retainer Fee is limited to up to 18 days per calendar year per recipient per provider.

2. Community Living – Group Home trial experience is limited to a maximum of 7 days or overnight stays per provider.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living - Group Home Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living - Group Home

Provider Category:

Agency

Provider Type:

Community Living - Group Home Provider

Provider Qualifications

License *(specify):*

Licensed DDA Community Residential Services Provider

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability residential services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum,

the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Community Living- Group Home services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications;

M. Have an organizational structure that assures services for each residence as specified in the PCP and the availability of back-up and emergency support 24 hours a day;

N. Complete and sign any agreements required by the Maryland Department of Health or DDA;

O. Be licensed by the OHCQ;

P. All providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;

Q. Have a signed Medicaid provider agreement;

R. Have documentation that all vehicles used in the provision of
services have automobile insurance; and

S. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency, as well as volunteers, utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Satisfactorily complete necessary pre/in-service training based on the PCP;

6. Satisfactorily complete required orientation and training designated by DDA;

7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH - For approval of provider license and licensed site.

2. Provider for verification of individual staff members' licenses, certifications, and training, as applicable.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

A. Day Habilitation services provide the participant with the 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.

1. Teaching methods based on recognized best practices are used such as systematic instruction.

2. Meaningful activities under this service will provide the participant with opportunities to learn new skills, build positive social skills and interpersonal skills, achieve greater independence, and develop personal choice including:

a. Learning skills for employment

b. Learning social skills;

c. Learning effective communication;

d. Learning problem solving;

e. Engaging in safety practices;

f. Performing household chores in a safe and effective manner; and

g. Performing self-care.

B. Day Habilitation services may include participation in the following regularly scheduled meaningful activities:

1. Learning general skills that can be used to do the type of work the person is interested in;

2. Participating in self-advocacy classes/activities;

3. Participating in local and community events;

4. Volunteering;

5. Training and supports designed to maintain abilities and to prevent or slow loss of skills for participants with declining conditions;

6. Time-limited participation in Project Search, or similar programs approved by the DDA;

7. Transportation services; and

8. Nursing Support Services. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.

C. This Medicaid waiver program service includes provision of:

1. Direct support services, for provision of services as provided in Sections A-B above; and

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation to, from, and within this Medicaid waiver program service;

b. Delegated nursing tasks or other Nursing Support Services covered by this Medicaid waiver program, based on the participant's assessed need; and

c. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary school.

B. Day Habilitation services can be provided in a variety of settings in the community or in a facility owned or operated by the provider agency.

1. Services may take place in non-residential settings separate from a participant's private residence or other residential living arrangements.

2. Supports may be provided virtually in a participant's private residence and other DDA residential living arrangements.

C. Services may also be provided in small groups (i.e., 1 to 5 participants) or large groups (i.e., 6 to 10 participants). The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's assessed level of service need.

1. Based on the participant's assessed need, the DDA may authorize a 1:1 or 2:1 staff-to-participant ratio.

2. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participant ratio:

a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio necessary 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 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.

d. 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.

D. Day Habilitation services are separate and distinct from other Waiver services, including residential services.

E. An individualized schedule is required to provide an estimate of what the participant will do and where the participant will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires and circumstances of the participant. The individualized schedule will be based on a PCP.

F. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The Provider must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation.

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

G. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program service; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Medicaid waiver program service.

H. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

I. Day Habilitation includes supports for volunteering and time limited generic paid and unpaid internships and apprenticeships for development of employment skills.

J. Day Habilitation does not include meals as part of a nutritional regimen.

K. Day Habilitation does not include vocational services that: (1) teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility-based job or (2) are delivered in an integrated work setting through employment supports.

1. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

2. If these services are deemed by the participant’s person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant’s needs shall be documented in the participant’s file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

L. Day Habilitation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Employment Services, Medical Day Care, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

M. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

N. Nursing Support Services, as applicable, can be provided during Day Habilitation activities so long as it is not the primary or only service provided. The scope of the Nursing Support Services are defined under the stand-alone service in Appendix C.

O. In the event that additional Nursing Support Services Delegation training supports are needed, as indicated in the HRST because of a change in the participant’s health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA’s Regional Office and additional standalone Nursing Support Services hours can be authorized.

P. 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.

Q. Direct Support Professional services may be provided in an acute care hospital for the purposes of supporting the participant’s personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary Waiver services:

a. Must be identified in the individual's file;

b. Must be provided to meet the individual's needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserve the participant's functional abilities.

R. Virtual Supports

1. Virtual support is an electronic method of service delivery.

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including HIPAA, as amended by the HITECH Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.

3. Supports provided virtually support a participant to reach identified outcomes in their PCP.

4. Supports provided virtually may not be used for the provider's convenience.

5. This Medicaid waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Medicaid waiver program service.

7. Supports provided virtually cannot be used to assess a person for a medical emergency.

8. The provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address:

a. Identifying whether the person'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 person's home), and ensuring they are present while services are being provided virtually, as indicated, in case the person experiences an emergency; and

c. How a person will get emergency interventions if the person experiences an emergency, including contacting 911 if necessary.

******** CONTINUED BELOW DUE TO SPACING LIMITATIONS**********

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**********CONTINUED FROM ABOVE DUE TO SPACING LIMITATIONS**********

9. MDH-licensed providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. 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.

S. Day Habilitation services are separate and distinct from residential services.

1. Participants may return home or to the provider operated site during time-limited periods of the day to participate in virtual supports as indicated in the participant's file and service implementation plan.

2. Supports delivered virtually can happen in the home or a licensed residential setting when the participant does not need paid direct support.

3. Residential and Personal Support Services cannot be billed during these times.

T. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

*****Specify applicable (if any) limits on the amount, frequency, or duration of this service:**********

Day Habilitation services may not exceed a maximum of 8 hours per day or 40 hours per week including in combination with any of the following other Medicaid waiver program services in a single day: including other Employment Services–Job Development, Career Exploration, and Community Development Services.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Day Habilitation Service Provider

Provider Qualifications

License *(specify):*

Licensed DDA Day Habilitation Service Provider

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards :

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability day habilitation and community engagement services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Day Habilitation;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and MDAT ;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA and

2. Be licensed by the OHCQ;

3. All providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;

4. Have a signed Medicaid provider agreement;

5. Have documentation that all vehicles used in the provision of services have automobile insurance; and

6. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have DDA required training, credentials, license, or certification;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Satisfactorily complete necessary pre/in-service training based on the PCP;

6. Satisfactorily complete required orientation and training designated by DDA;

7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

8. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH - for approval of Day Habilitation provider.

2. Provider for verification of individual staff member’s licenses, certifications, and training, as applicable.

3. Financial Management and Counseling Services providers, as described in Appendix E.

Frequency of Verification:

1. MDH – Initially and at least every 3 years for license and license sites.

2. Provider – Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services providers provider - Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Live-in Caregiver (42 CFR § 441.303(f)(8))

Alternate Service Title (if any):

Live-in Caregiver Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
07 Rent and Food Expenses for Live-In Caregiver	07010 rent and food expenses for live-in caregiver
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The purpose of Live-in Caregiver Supports is to pay a portion of the cost of rent and food that can be reasonably attributed to a live-in personal caregiver who is residing in the same household with a participant.

SERVICE REQUIREMENTS:

A. A live-in caregiver is defined as someone who is residing in the same household with a participant who is also providing supports and services in the participant's home.

B. Explicit agreements, including detailed service expectations, arrangement termination procedures, recourse for unfulfilled obligations, and monetary considerations must be executed and signed by both the participant receiving services (or their legal representative) and the caregiver. This agreement is developed by the participant receiving services (or their legal guardian or authorized representative), the caregiver, and provider (as applicable). The agreement must be forwarded to the CCS for submission to the DDA as part of the service request authorizations.

C. The individual in services has the rights of tenancy but the live-in caregiver does not, even though they may be listed on a lease as an occupant.

D. Live-in Caregiver Supports are not available if the participant resides in their family's home, the caregiver's home, or in a residence owned or leased by a DDA-licensed provider.

E. The Medicaid waiver program will reimburse this service only for the months in which the service agreement is successfully carried out, without assuming liability for unmet rental obligations. When entering into the service agreement with the caregiver, the participant (or their legal representative) will take on the risk for all unmet rental obligations.

F. Live-In Caregiver Rent is not available to participants receiving support services in residential models, including Community Living-Enhanced Supports, Community Living-Group Home, Shared Living and Supported Living services.

G. A legally responsible person, parent, spouse, 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.

H. Siblings may be paid to provide this Waiver service, unless they are a legally responsible person or legal guardian.

I. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Live-in Caregiver Supports is limited based on the following:

1. The cost of rent, associated with the live-in caregiver, must be calculated as follows:

a. The difference in cost between:

(i) A unit sufficient to house the participant only; and

(ii) A unit sufficient to house the participant and the live-in caregiver under this Medicaid waiver program service; and

b. That cost of rent must be based on, and not exceed, the Fair Market Rent for the jurisdiction where the unit is located as determined by the Department of Housing and Urban Development.

2. The cost of food, associated with the live-in caregiver, must be calculated, as follows:

a. The cost of food attributable solely to sustaining the live-in caregiver; and

b. That cost must be based on, and not exceed, the U.S. Department of Agriculture's Monthly Food Plan Cost at the 2-person moderate plan level.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Live-in Caregiver Supports

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the MDH to provide at least one Medicaid waiver service; and

2. Complete the MDH provider application to be an OHCDS provider.

OHCDS providers shall verify qualified entity/vendor, funding amount, and payments including:

1. Property manager and landlord chosen by the individual providing residences at a customary and reasonable cost within limits established;

2. Local and community grocery stores for the purchase of food at a customary and reasonable cost within limits established; and

3. Have a copy of the same available upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of OHCDS.

2. OHCDS providers for verification of qualified entity/vendor.

Frequency of Verification:

1. OHCDS – Initially and at least every 3 years.

2. OHCDS providers – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Medical Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. MDC includes the following services:

1. Health care services;

2. Nursing services;

3. Physical therapy services;

4. Occupational therapy services;

5. Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene;

6. Nutrition services;

7. Social work services;

8. Activity Programs; and

9. Transportation services.

SERVICE REQUIREMENTS:

A. A participant must attend the MDC a minimum of 4 hours per day for the service to be reimbursed.

B. MDC services cannot be billed during the same period of time that the individual is receiving other meaningful day or employment Waiver services.

C. Services and activities take place in non-institutional, community-based settings.

D. Nutritional services do not constitute a full nutritional regimen.

E. This Waiver service is only provided to individuals age 16 and over.

F. MDC services may not be provided at the same time as the direct provision of Career Exploration, Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Services, Nursing Support Services, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

G. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant’s file.

2. If these services are deemed by the participant’s person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant’s needs shall be documented in the participant’s file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

H. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

I. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MDC Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Medical Day Care

Provider Category:

Agency

Provider Type:

MDC Providers

Provider Qualifications

License *(specify):*

Licensed MDC Providers as per COMAR 10.12.04

Certificate *(specify):*

Other Standard *(specify):*

All providers must meet and comply with the federal community settings regulations and requirements prior to enrollment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Maryland Department of Health

Frequency of Verification:

Every 2 years and in response to complaints.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Personal Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Personal Supports are individualized supports, delivered in a personalized manner, to support independence in a participant's own home and community in which the participant wishes to be involved, based on their personal resources.

B. Personal Supports provide habilitative services and overnight staff to assist participants who live in their own or family homes with acquiring, building, or maintaining the skills necessary to maximize their personal independence. These services include:

1. In home skills development including budgeting and money management; completing homework; maintaining a bedroom or home; being a good tenant; meal preparation; personal care; house cleaning/chores; and laundry;

2. Community integration and engagement skills development needed to be part of a family event or community at large. Community integration services facilitate the process by which participants integrate, engage, and navigate their lives at home and in the community. They may include the development of skills or providing supports that make it possible for participants and families to lead full integrated lives (e.g., grocery shopping; banking; getting a haircut; using public transportation; attending school or social events; joining community organizations or clubs; any form of recreation or leisure activity; volunteering; and participating in organized worship or spiritual activities) and health management assistance for adults (e.g., learning how to schedule a health appointment; identifying transportation options; and developing skills to communicate health status, needs, or concerns); and

3. Overnight services.

C. This Medicaid waiver program service includes the provision of:

1. Direct support services, providing habilitation services to the participant;

2. The following services provided, in combination with, and incidental to, the provision of habilitation services:

a. Transportation to, from, and within this Medicaid waiver program service;

b. Delegated nursing tasks, based on the participant's assessed need; and

c. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. Personal Supports Services under the Medicaid waiver differ in scope, nature, and provider training and qualifications from personal care services in the State Plan.

B. 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.

1. Based on the participant's assessed need, the DDA may authorize an enhanced rate, overnight supports, and 2:1 staff-to-participant ratio supports.

2. The following criteria will be used to authorize the enhanced rate:

a. The participant has an approved Behavior Support Plan documenting the need for enhanced supports necessary to support the person with specific behavioral needs; or

b. The participant has a Nursing Care Plan developed by an active DDA Registered Nurse Case Manager/Delegating Nurse (CM/DN) documenting the need for enhanced supports necessary to support the person with specific health and safety needs.

c. The DDA may authorize an enhanced rate 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.

d. 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.

3. The following criteria will be used to authorize 2:1 staff-to-participant ratio:

a. The participant has an approved Behavioral Support Plan documenting the need for 2:1 staff-to-participant ratio necessary to support the person with specific behavioral needs; or

b. The participant has a Nursing Care Plan developed by an active DDA Registered Nurse Case Manager/Delegating Nurse (CM/DN) documenting the need for 2:1 staff-to-participant ratio 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.

d. 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.

4. The following criteria will be used to authorize overnight supports:

a. The participant has an approved Behavior Support Plan documenting the need for overnight supports necessary to support the person with specific behavioral needs; or

b. The participant has a Nursing Care Plan developed by an active DDA Registered Nurse Case Manager/Delegating Nurse (CM/DN) documenting the need for overnight supports necessary to support the person with specific health and safety

needs.

c. The DDA may authorize overnight 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.

d. 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. Overnight services must be specifically documented within the file. This includes information that details the need for the overnight supports, including alternatives explored such as the use of Assistive Technology and other strategies.

C. 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.

D. Personal Support Services includes the provision of supplementary care by legally responsible persons necessary to meet the participant's extraordinary care needs, as per Appendix C-2, due to the participant's disability that are above and beyond the typical, basic care a legally responsible person would ordinarily perform or be responsible to perform on behalf of a waiver participant.

E. Personal Supports are available:

1. Before and after school;

2. Times when a student is not receiving educational services, for example, when school is not in session;

3. During the day;

4. Evenings;

5. Overnight; and

6. When Nursing Supports Services are provided.

F. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation Services separately at the same time as provision of this Medicaid waiver program service;

2. The provider or participants self-directing their services must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation Services may not compromise the entirety of this Medicaid waiver program service.

G. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program; and

2. The delegated medication tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. Health tasks may not compromise the entirety of this Medicaid waiver program service.

H. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

I. For participants enrolled in the Self-Directed Services Delivery Model, this Medicaid waiver program service includes:

1. The reasonable and customary costs of training the participant's direct support staff, including First Aid and CPR certifications;

2. Travel reimbursement, benefits and leave time for the participant's direct support staff, subject to the following requirements:

a. The reimbursement, benefits and leave time requested are:

i. Within applicable reasonable and customary standards as established by DDA policy; or

ii. Required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws; and

b. Any reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws.

c. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the Self-Directed Services Delivery Model, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the recipient's PCP.

J. A legally responsible individual, legal guardian or a relative of a participant (who is not a spouse) may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

K. 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 the Maryland Medicaid State Plan, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant's needs must be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

M. 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.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SERVICE DEFINITION CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS

N. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT 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.

O. Personal Supports can be provided in a variety of community settings and activities that promote opportunities for increased independence and inclusion. Through the person-centered planning process, all opportunities should be explored based on the person's preferences and support their desired outcomes and goals. The setting should not have institutional qualities. Considering the person's overall PCP, activities should not isolate or segregate.

P. Direct Support Professional services may be provided in an acute care hospital for the purposes of supporting the participant's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary waiver services:

a. Must be identified in the individual's PCP;

b. Must be provided to meet the individual's needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserve the participant's functional abilities.

Q. Virtual Supports

1. Virtual supports is an electronic method of service delivery.

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including HIPAA or the HITECH Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.

3. Supports provided virtually must support a participant to reach identified outcomes in their PCP.

4. Supports provided virtually may not be used for the provider's convenience.

5. This Medicaid waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Medicaid waiver program service.

7. Supports provided virtually cannot be used to assess a participant for a medical emergency.

8. The provider and participants self-directing their services 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 person'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.

9. MDH-licensed providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. For participants self-directing who use individual providers to provide a Medicaid waiver program service through virtual supports, they must include it as a service delivery method in their provider service implementation plan or job description.

11. 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;

12. Personal Supports enhanced and overnight supports cannot be provided virtually.

R. 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.

S. The State maintains a list of service providers including Personal Supports providers. The DDA website includes a searchable Provider Directory.

****

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Legally responsible persons, legal guardians, and relatives may not be paid for greater than 40-hours per week for services.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Supports Provider
Individual	Personal Supports Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Personal Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability community integration, independent living skills, and personal care services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all Personal Support services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Personal Supports services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications and;

M. Complete and sign any agreements required by the MDH or DDA.

1. Have a signed Medicaid Provider Agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency, as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Complete necessary pre/in-service training based on the PCP;

5. Complete required orientation and training designated by the DDA;

6. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

7. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified provider.

2. Provider for verification of staff licenses, certifications, and training.

3. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Personal Supports Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

5. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services;

6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

7. Satisfactorily complete required orientation and training designated by the DDA;

8. Satisfactorily complete necessary pre/in-service training based on the PCP;

9. Have 3 professional references which attest to the provider’s ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

10. Demonstrate financial integrity through the IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

11. Complete and sign any agreements required by the MDH or DDA; and

12. Have a signed Medicaid Provider Agreement.

Employees of participants must meet the standards 1 through 6 noted above. They do not need to complete the DDA provider application.

Participants must submit forms and documentation as required by the Financial Management and Counseling Services agency. Financial Management and Counseling Services must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Personal Supports Professional.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. Respite can be provided in:

1. The participant’s own home;

2. The home of a respite care provider;

3. A licensed residential site; and

4. State overnight or youth camps, certified by the Maryland Department of Health.

SERVICE REQUIREMENTS:

A. Someone who lives with the participant may be the respite provider, as long as they are not the person who normally provides care for the participant. Respite may not be provided by the primary caregiver.

B. A legally responsible person or legal guardian or relative of a participant (who is not a spouse), may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

C. A neighbor or friend may provide services under the same safeguard requirements as defined in Appendix C-2-e.

D. Receipt of respite services does not preclude a participant from receiving other services on the same day. For example, the participant may receive meaningful day services (e.g., Employment Services or Day Habilitation) on the same day they receive respite services so long as these services are provided at different times.

E. Under self-directing services, the following applies:

1. Participant or their designated representative self-directing services is considered the employer of record;

2. Participant or their designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;

3. Respite Care Services include the cost associated with staff training such as First Aid and CPR; and

4. Respite Care Services staff, with the exception of legal guardians and relatives, must be compensated overtime pay as per the Fair Labor Standards Act from the self-directed budget.

F. Payment rates for services must be customary and reasonable, as established by the DDA.

G. Services are reimbursed based on:

1. A 15-minute rate, for services provided in the participant’s home or non-licensed respite provider’s home;

2. Daily rate, for services provided in a licensed residential site; or

3. Reasonable and customary fee, for a camp meeting applicable requirements.

H. Respite cannot replace day care while the participant’s parent or guardian is at work.

I. If respite is provided in a residential site, the site must be licensed. Services provided in the participant’s home or the home of a relative, neighbor, or friend does not require licensure.

J. Respite does not include funding for any fees associated with the respite care (for example, membership fees at a recreational facility, community activities, travel adventures (unless it is a day trip), vacations, or insurance fees).

K. Respite Care Services are not available to participants receiving support services in Community Living-Enhanced Supports, Community Living-Group Home, or Supported Living Services.

L. Respite Care Services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Services, Medical Day Care, Personal Supports, Supported Living, or Transportation Services.

M. Payment may not be made for services furnished at the same time as other services that include care and supervision. This includes Medicaid State Plan Personal Care Services as described in Code of Maryland Regulations 10.09.20, the Attendant Care Program and the In-Home Aide Services Program.

N. 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), and Department of Human Services (DHS), and any other federal, or State government funding program, must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program.

O. For participants enrolled in the Self-Directed Services Delivery, this Waiver program service includes:

1. The reasonable and customary costs of training the participant's direct support staff, including First Aid and CPR certifications;

2. Travel reimbursement, benefits and leave time for the participant's direct support staff, subject to the following requirements:

a. The reimbursement, benefits and leave time requested are:

i. Within applicable reasonable and customary standards as established by DDA policy; or

ii. Required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws; and

b. Any reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws.

c. Mileage reimbursement, under the Self-Directed Services Delivery, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the participant's file PCP.

3. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

P. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Respite Care Services 15-minute and daily, total hours may not exceed 720 hours within each Person-Centered Plan year.

2. The total cost for camp cannot exceed $7,248 within each plan year.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Camp
Individual	Respite Care Supports Professional
Agency	OHCDS Provider
Agency	Respite Care Provider
Agency	Licensed Community Residential Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Camp

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Camp must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting the following standards:

A. State certification and licenses as a camp including overnight and youth camps as per Code of Maryland Regulations 10.16.06, unless otherwise approved by the DDA; and

B. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA;

C. Have a signed Medicaid Provider Agreement;

D. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy;

2. Out of state camps may be approved by DDA based on state licensure requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of camps.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Individual

Provider Type:

Respite Care Supports Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be certified based on compliance with meeting the following standards:

1. Be at least 16 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2;

4. 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;

5. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services;

6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

7. Satisfactorily complete required orientation and training designated by the DDA;

8. Satisfactorily complete necessary pre/in-service training based on the Person-Centered Plan;

9. Have 3 professional references which attest to the provider’s ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

10. Demonstrate financial integrity through Internal Revenue Services, Maryland Department of Health, and Medicaid Exclusion List checks;

11. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA; and

12. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above. They do not need to complete the DDA provider application. Individuals must submit forms and documentation as required by the Financial Management and Counseling Services agency. Financial Management and Counseling Services must

ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Respite Care Supports Professional.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least one Medicaid Waiver service; and

2. Complete the DDA provider application to be an Organized Health Care Delivery System provider.

Organized Health Care Delivery System providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 16 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Satisfactorily complete necessary pre/in-service training based on the Person-Centered Plan;

6. Satisfactorily complete required orientation and training designated by the DDA;

7. 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;

8. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

10. Out of state camps may be approved by DDA based on state licensure requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Organized Health Care Delivery System.

2. Organized Health Care Delivery System providers for verification of entities and individuals they contract or employ.

Frequency of Verification:

1. Organized Health Care Delivery System – Initially and at least every 3 years.

2. Organized Health Care Delivery System providers – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality respite care or personal case assistance services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of Respite Care Services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Respite Care Services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the Internal Revenue Service and State Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or that spend any time alone with a participant must meet the following minimum standards:

1. Be at least 16 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.;

3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Complete necessary pre/in-service training based on the Person-Centered Plan;

6. Satisfactorily complete required orientation and training designated by the DDA;

7. 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;

8. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of provider.

2. Respite Care Services Provider for verification of direct support staff.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. MDH - Respite Care Services Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Licensed Community Residential Services Provider

Provider Qualifications

License *(specify):*

Licensed Community Residential Services Provider

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality respite care or personal care assistance services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of Respite Care Services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Respite Care Services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be licensed by the Office of Health Care Quality;

G. Be in good standing with the Internal Revenue Service and State Department of Assessments and Taxation;

H. Have Workers' Compensation Insurance;

I. Have Commercial General Liability Insurance;

J. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

K. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

L. Satisfactorily complete required orientation and training;

M. Comply with the DDA standards related to provider qualifications; and

N. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA.

O. Have a signed Medicaid Provider Agreement;

P. Have documentation that all vehicles used in the provision of services have automobile insurance;

Q. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period; and

R. Respite Care Services provided in a provider owned and operated residential site must be licensed.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 16 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.;

3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);

4. Training on additional requirements based on the participant's preferences and level of needs;

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-;

6. Satisfactorily complete necessary pre/in-service training based on the Person-Centered Plan;

7. Satisfactorily complete required orientation and training designated by the DDA;

8. 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;

9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of provider license and licensed site.

2. Licensed Community Residential Services Provider for verification of direct support staff and camps.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Licensed Community Residential Services Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment (phased out effective years 3, 4, and 5)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03030 career planning
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Supported Employment services include a variety of supports to help an individual identify career and employment interest, as well as to find and keep a job.

B. Supported Employment activities include:

1. Individualized job development and placement;

2. On-the-job training in work and work-related skills;

3. Facilitation of natural supports in the workplace;

4. Ongoing support and monitoring of the individual's performance on the job;

5. Training in related skills needed to obtain and retain employment such as using community resources and public transportation;

6. Negotiation with prospective employers; and

7. Self-employment supports.

C. Supported Employment services include:

1. Direct support services that enable the participant to gain and maintain competitive integrated employment, as provided in Sections A-B above;

2. The following services provided in combination with, and incidental to, the provision of this Waiver program service:

a. Transportation to, from, and within this Waiver program service;

b. Delegated nursing tasks, based on the participant’s assessed need;

c. Personal care assistance, based on the participant’s assessed need; and

3. Nursing Support Services. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary school.

B. Services and supports are provided for participants in finding and keeping jobs paid by a community employer including self-employment.

C. The level of staffing and meaningful activities provided to the participant under this Waiver program service must be based on the participant's assessed level of service need.

D. Under the Traditional Service Delivery System, Supported Employment is paid based on a daily rate, requiring that a minimum of 4 hours of this Waiver program service be provided in order to be paid. Participants can engage in Supported Employment activities when they are unable to work 4 hours.

E. Under the Traditional Service Delivery Model, a participant's PCP may include a mix of employment and day related daily Waiver services units such as Day Habilitation, Community Development Services, Career Exploration, and Employment Discovery and Customization provided on different days.

F. Supported Employment services does not include:

1. Volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited; and

2. Payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.

G. Medicaid funds cannot be used to defray the expenses associated with starting up or operating a business.

H. If transportation is provided as part of this Waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Waiver program service;

2. The provider or participants self-directing their services must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's PCP; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation services may not compromise the entirety of this Waiver program service.

I. If direct support staff perform delegated nursing tasks as part of this Waiver program service, then:

1. The participant must receive Nursing Support Services under this Waiver program; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are currently certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Waiver program service.

J. If personal care assistance services are provided as part of this Waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

K. A relative of a participant (who is not a spouse) may be paid to provide this service, in accordance with the applicable requirements set forth in Appendix C-2.

L. A relative of a participant may not be paid for more than 40-hours per week of services.

M. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by Maryland Medicaid State Plan, MSDE, DORS, DHS, or any other federal, or State government funding

program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's PCP. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program.

N. Documentation must be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

O. Until the service transitions to the LTSSMaryland system, Supported Employment Services daily service units are not available:

1. On the same day a participant is receiving Career Exploration, Community Development Services, Day Habilitation, Medical Day Care, or Employment Discovery and Customization services under the Traditional Services Delivery Model; and

2. At the same time as the direct provision of Behavioral Support Services, Community Living—Enhanced Supports, Community Living-Group Homes, Nursing Support Services, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

A. Services which are provided virtually, must:

1. Be provided in accordance with federal and State requirements, policies, guidance, and regulations, including HIPAA and the HITECH Act and their applicable regulations to protect the privacy and security of the participant's protected health information;

2. Support a participant to reach identified outcomes in their PCP;

3. Not be used for the provider's convenience; and

4. The 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Provider
Individual	Supported Employment Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment (phased out effective years 3, 4, and 5)

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Except for currently DDA licensed or certified Supported Employment providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Supported Employment services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and MDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement for Conditions for Participation.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as CQL or CARF for similar services for individuals with developmental disabilities, and be in good standing with the IRS and MDAT.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below;

3. Possess current First Aid and CPR certification;

4. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

6. Complete required orientation and training designated by the DDA;

7. Complete necessary pre/in-service training based on the PCP;

8. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of certified provider.

2. Provider for verification of individual staff members’ licenses, certifications, and training.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment (phased out effective years 3, 4, and 5)

Provider Category:

Individual

Provider Type:

Supported Employment Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification;

3. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

7. Complete required orientation and training designated by the DDA;

8. Complete necessary pre/in-service training based on the PCP;

9. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;

10. Demonstrate financial integrity through the IRS, Department, and Medicaid Exclusion List checks;

11. Have a signed DDA Provider Agreement for Conditions for Participation; and

12. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of certified Supported Employment Professional.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Assistive Technology and Services can be used as a creative solution to help with a participant's health and safety, build relationships, and increase independence at home, in the community, or at work.

The purpose of Assistive Technology and Services is to maintain or improve a participant’s functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.

B. Assistive Technology and Services includes:

1. Assistive Technology needs assessment;

2. Acquisition of Assistive Technology;

3. Installation and instruction on use of Assistive Technology;

4. Monthly service fees; and

5. Maintenance of Assistive Technology.

C. Assistive Technology means an item, computer application, piece of equipment, or product system. Assistive Technology may be acquired commercially, modified, or customized.

D. Assistive Technology devices includes:

1. 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;

2. Blind and low vision devices, such as video magnifiers, devices with optical character recognizer (OCR) and Braille note takers;

3. Deaf and hard of hearing devices, such as alerting devices, alarms, and assistive listening devices;

4. Devices for computers and telephone use, such as alternative mice and keyboards or hands-free phones;

5. Environmental control devices, such as voice activated lights, fans, and door openers;

6. Aides for daily living, such as weighted utensils, adapted writing implements, and dressing aids;

7. Cognitive support devices and items, such as task analysis applications or reminder systems;

8. Alert support devices, such as health monitoring devices, including blood pressure bands and oximeter; and

9. Adapted toys and specialized equipment such as specialized car seats and adapted bikes.

E. Assistive Technology Service means a service that directly assists participants in the selection, acquisition, use, or maintenance of an Assistive Technology device. Assistive Technology services only include:

1. Assistive Technology needs assessment;

2. Programs, materials, and assistance in the development of adaptive materials;

3. Training or technical assistance for the participant and their support network including family members;

4. Repair and maintenance of devices and equipment;

5. Programming and configuration of devices and equipment;

6. Coordination and use of Assistive Technology devices and equipment with other necessary therapies, interventions, or services in the PCP; and

7. Purchasing or leasing of Assistive Technology devices.

F. Specifically excluded under this service are:

1. Wheelchairs, architectural modifications, adaptive driving, vehicle modifications, and devices requiring a prescription by physicians or other licensed health care providers when these items are covered through: (i) the Medicaid State Plan as Durable Medical Equipment (DME); (ii) other Medicaid waiver program services (e.g., environmental modification and vehicle modifications); (iii) the Division of Rehabilitation Services (DORS); or (iv) any other State funding program;

2. Services, equipment, items, or devices that are experimental or not authorized by applicable State or Federal authority; and

3. Smartphones and associated monthly service line and data cost.

SERVICE REQUIREMENTS:

A. 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.

B. 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.

C. The Assistive Technology needs assessment must contain the following components:

1. A description of the participant’s needs and goals;

2. A description of the participant’s functional abilities without Assistive Technology;

3. A description of whether and how Assistive Technology will meet the participant’s needs and goals; and

4. A list of all Assistive Technology, and other Medicaid waiver program services (including a combination of any of the elements listed) that would be most effective to meet the technology needs of the participant.

D. If the item costs over $2,500, the most cost-effective option that best meets the participant's needs shall be selected from the list developed in the Assistive Technology needs assessment described in C. above.

E. 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 for review and selection by the DDA.

F. Upon delivery to the participant (including installation) or maintenance performed, the Assistive Technology must be in good operating condition and repair in accordance with applicable specifications.

G. 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.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver Program.

H. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

I. A legally responsible person, relative, or legal guardian of the participant cannot be paid by the Waiver program, either directly or indirectly, to provide this Waiver program service.

J. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organized Health Care Delivery System Provider
Individual	Assistive Technology Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Services

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved to provide at least one Medicaid waiver service;

2. Complete the MDH provider application to be an OHCDS provider.

Organized Health Care Delivery System providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Individuals performing assessments for Assistive Technology (except for Speech Generating Devices) must meet following requirements:

a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);

b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or

c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).

2. Individuals performing assessments for any Speech Generating Devices must meet the following requirements:

a. Need assessment and recommendation must be completed by a licensed Speech Therapist;

b. Program and training can be conducted by a Rehabilitation Engineering and Assistive Technology Society of North America Assistive Technology Practitioner or California State University Northridge (CSUN) Assistive Technology Applications Certificate professional.

3. Assistive Technology Specialist/Practitioner must have an acceptable certification from any of the following:

a. Rehabilitation Engineering and Assistive Technology Society of North America Assistive Technology Practitioner;

b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or

c. Shift Enabling Technology Integration Specialist (ETIS) Certification; or

d. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); and

e. Minimum of 3 years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. Assistive Technology Licensed professional must have:

a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists License for Speech-Language Pathologist; or

b. Maryland Board of Occupational Therapy Practice License for Occupational Therapist.

5. Entity designated by the Division of Rehabilitative Services as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Organized Health Care Delivery System providers.

2. Organized Health Care Delivery System providers for verification of entities and individuals they contract or employ.

Frequency of Verification:

1. Organized Health Care Delivery System providers– Initially and at least every 3 years.

2. Organized Health Care Delivery System providers – prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Services

Provider Category:

Individual

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification in an area related to the specific type of technology needed as noted below;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Have Commercial General Liability Insurance;

5. Satisfactorily complete required orientation and training designated by DDA;

6. Satisfactorily complete necessary pre/in-service training based on the PCP;

7. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

8. Demonstrate financial integrity through the IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

9. Complete and sign any agreements required by the Maryland Department of Health or DDA; and

10. Have a signed Medicaid Provider Agreement.

11. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for a 3 year period unless otherwise noted in the approval letter.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Individuals performing assessments for Assistive Technology (except for Speech Generating Devices) must meet any of the following requirements:

a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);

b. California State University Northridge (CSUN) Assistive Technology Applications Certificate;

c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).

2. Individuals performing assessments for any Speech Generating Devices must meet the following requirements:

a. Needs assessment and recommendation must be completed by a licensed Speech Therapist;

b. Program and training can be conducted by a RESNA ATP or CSUN Assistive Technology Applications Certificate professional.

3. Assistive Technology Specialist/Practitioner must have an acceptable certification from any of the following:

a. RESNA ATP;

b. CSUN Assistive Technology Applications Certificate;

c. Shift Enabling Technology Integration Specialist (ETIS) Certification; or

d. CCC-SLP; and

e. Minimum of 3 years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. Assistive Technology Licensed professionals must have:

a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists License for Speech-Language Pathologist; or

b. Maryland Board of Occupational Therapy Practice License for Occupational Therapists; or

c. Entity designated by the DORS as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Assistive Technology Professional.

2. Financial Management and Counseling Service (FMCS) provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Service provider - prior to services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Behavioral Support Services are an array of services to assist participants who, without such supports, are experiencing or are likely to experience difficulty at home or in the community as a result of behavioral, psychological, social, or emotional issues. These services seek to help understand a participant's communication and behavior and its function is to develop a Behavior Support Plan with the primary aim of enhancing the participant's independence, quality of life, and inclusion in their community.

B. Behavioral Support Services includes:

1. Behavioral Assessment - identifies a participant's challenging behaviors by collecting and reviewing relevant data, assessing clinically relevant environment, discussing the information with the participant's support team, and if appropriate, developing a Behavior Support Plan that best addresses the function of the behavior;

2. Behavioral Consultation - services that oversee, monitor, and modify the Behavior Support Plan; and

3. Brief Support Implementation Services - a time limited service that provides direct assistance and models behavioral

strategies to families, staff, caregivers, and any other individuals supporting the participant so they can independently implement the Behavior Support Plan.

SERVICE REQUIREMENTS:

A. Behavioral Assessment:

1. Is based on the principles of person-centered thinking, a comprehensive Functional Behavioral Assessment (FBA), and supporting data;

2. Is performed by a qualified clinician;

3. Requires development of specific hypotheses for a participant's challenging behavior, a description of the behaviors in behavioral terms, to include where the person lives and spends their time, frequency, duration, intensity/severity, and variability/cyclicality of the behaviors;

4. Must be based on a collection of current specific behavioral data; and

5. Includes the following:

a. An onsite observation of the interactions between the participant and their caregiver(s) and/or others who support them in multiple settings and observation of the relationships between the participant and others in their environment, and implementation of existing strategies (if any);

b. An environmental assessment of all primary environments;

c. Assessment of communication skills and how challenges with communication may relate to behavior;

d. An assessment of the participant's medical conditions and needs, and how they relate to their behavior, (somatic and psychiatric), the rationale for prescribing each medication, and the potential side effects of each medication;

e. A participant's history, including trauma history (if applicable), based upon the records and interviews with the participant and with the people important To and For the person (e.g., parents, caregivers, vocational staff, etc.);

f. Record reviews and interviews with the participant and individuals supporting the participant, with respect to possible reasons for the challenging behaviors; ways to support positive behaviors; and obtaining suggestions of positive and effective ways to communicate wants and needs and decrease challenging behaviors;

g. Recommendations, after discussion of the results within the participant's interdisciplinary team, on behavioral support strategies, including those required to be developed in a Behavior Support Plan; and

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.

B. Behavioral Consultation services only include:

1. Recommendations for subsequent professional evaluation services (e.g., Psychiatric, Neurological, Psychopharmacological, etc.), not identified in the Behavioral Assessment, that are deemed necessary and help support positive behavior;

2. Graphing and analysis of collected data to identify trends and patterns of target behaviors that can be shared with other team members in consultation and educational efforts.

3. Consultation, subsequent to the development of the Behavioral Support Plan which may include speaking with the participant's Psychiatrists and other medical/therapeutic practitioners;

4. Developing, writing, presenting, and monitoring the strategies for working with the participant and their caregivers;

5. 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, ways to communicate with and support the participant, and enabling the participant to participate in environments to optimize the participant's community inclusion in the most integrated environment;

6. Developing, presenting, and providing ongoing education on recommendations, strategies, and next steps to ensure that the participant is able to continue to participate in home and community environments, including those where they live, spend their days, work, volunteer, etc. to optimize community inclusion in the most integrated environment;

7. Ongoing assessment of progress in all appropriate environments against identified goals related to the Behavioral Support Plan.

8. Preparing written progress notes on the status of participant's goals identified in the Behavior Support Plan at a minimum include the following information:

a. Assessment of behavioral and environmental supports in the environment;

b. Specific Behavior Support Plan interventions and outcomes based on the participant's goals;

c. Data, trend analysis and graphs to detail progress on target behaviors identified in a Behavior Support Plan; and

d. Recommendations for ongoing supports;

9. Development and updates to the Behavior Support Plan as required by regulations;

10. Monitoring and ongoing assessment of the implementation of the Behavior Support Plan based on the following:

a. At least monthly for the first 6 months; and

b. At least quarterly after the first 6 months or more frequently as determined by progress in meeting the participant's identified goals.

11. Progress notes must include the following components:

a. Assessment of behavioral supports in the environment;

b. Progress notes detailing the specific interventions, implemented in accordance with the behavior plan, and outcomes for the participant;

c. Data, trend analysis, and graphs to detail progress on target behaviors identified in a behavior plan; and

d. Recommendations.

C. Brief Support Implementation Services includes:

1. Onsite execution and modeling of identified behavioral support strategies;

2. Timely semi-structured written feedback to the clinicians on the provision and effectiveness of the Behavior Support Plan and strategies for supporting positive behavior;

3. Participation in on-site meetings or instructional sessions with the participant's support network regarding the recommendations, strategies, and next steps identified in the Behavior Support Plan;

4. Brief Support Implementation Services cannot be duplicative of other services being provided (e.g., direct supports, 1:1 or 2:1 dedicated supports); and

5. 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.

D. The DDA policies, procedure, guidance, and training curriculum must be followed when developing a Behavior Support Plan.

E. 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 COMAR 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.

F. 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.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program.

G. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

H. Behavioral Assessment is reimbursed based on a milestone for a completed assessment.

I. The Behavior Support Plan is reimbursed based on a milestone for a completed plan.

J. Behavioral Support Services may not be provided at the same time as the direct provision of Community Living – Enhanced Supports or Respite Care Services.

K. Behavioral Consultation and Brief Support Implementation Services service hours are based on assessed needs, supporting data, plan implementation, and authorization from the DDA.

L. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 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.

M. A legally responsible person, relative, or legal guardian of the participant cannot be paid by the Waiver program, either directly or indirectly, to provide this Medicaid waiver program service.

N. Virtual Supports

1. Virtual supports is an electronic method of service delivery

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information;

3. Supports provided virtually support a participant to reach outcomes identified in their Person-Centered Plan;

4. Supports provided virtually may not be used for the provider's convenience;

5. This Waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

*** continued from Service Definition (Scope) DUE SPACE LIMITATIONS****

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

7. Supports provided virtually cannot be used to assess a participant for a medical emergency.

8. 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 person will get emergency interventions if the participant experiences an emergency, including contacting 911 if necessary.

9. MDH-licensed providers providing a Waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. For participants in self-direction using individual providers to provide a Medicaid waiver program service through virtual supports, they must include it as a service delivery method in their provider service implementation plan or job description.

11. The 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.

O. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

P. Behavioral Supports Services shall be provided in a holistic manner including assessments, consultations, and development of behavioral strategies in all environments (e.g., home, community, employment, day program, residential program). There may only be one Behavioral Support provider authorized, at a time, to support a participant.

******* Specify applicable (if any) limits on the amount, frequency, or duration of this service: **********

1. Behavioral Assessment and Behavior Support Plan is limited to 1 per PCP year.

2. For Behavioral Consultation and Brief Support Implementation Services, the Waiver program will fund up to a maximum of 8 hours per day.

Note: Behavior Support Plan updates are completed under Behavioral Consultation

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavioral Support Services Provider
Individual	Behavioral Support Services Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

Behavioral Support Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disabilities behavioral services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all Behavioral Support Services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Behavioral Support Services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and Maryland State Department of Assessments and Taxation (SDAT);

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training designated by the DDA;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA.

N. Have a signed Medicaid provider agreement.

O. Have documentation that all vehicles used in the provision of services have automobile insurance; and

P. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for a 3 year period unless otherwise noted in the approval letter.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Complete necessary pre/in-service training based on the PCP; and

5. Complete required orientation and training designated by the DDA.

An individual is qualified to complete the Behavioral Assessment and 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 defined 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

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 analysis including antecedent interventions;

h. Identifying person-centered outcomes;

i. Selecting intervention strategies to achieve person-centered outcomes;

j. Staff/caregiver training;

k. Support plan monitors and revisions; and

l. Positive behavioral supports and trauma informed care.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Behavioral Support Services Provider.

2. Providers for verification of clinician’s and staff qualifications and training.

Frequency of Verification:

1. MDH - Initially and at least every 3 years.

2. Providers – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Behavioral Support Services Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Complete required orientation and training designated by the DDA;

5. Complete necessary pre/in-service training based on the PCP;

6. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;

7. Have Commercial General Liability Insurance;

8. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

9. Complete and sign any agreements required by the Maryland Department of Health or DDA; and

10. Have a signed Medicaid Provider Agreement.

An individual is qualified to complete the Behavioral Assessment 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 Analysis (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

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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Behavioral Support Services Professional.

2. Financial Management and Counseling Services provider, as described in Appendix E for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Development Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Community Development Services provide the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities.

B. Community-based activities under this service will provide the participant access and supports to engage in community-based activities for development, acquisition, and maintenance of skills to increase the participant's independence related to community integration with individuals without disabilities, such as:

1. Promoting positive growth and developing general skills and social supports necessary to gain, retain, or advance competitive integrated employment opportunities;

2. Learning social skills that can promote further community integration; and

3. Learning self-advocacy skills.

C. Community Development Services may include participation in the following activities:

1. Engaging in activities that facilitate and promote integration and inclusion of a participant in their chosen community, including identifying a path to employment for working age participants;

2. Travel training;

3. Participating in self-advocacy classes and activities;

4. Participating in local community events;

5. Volunteering;

6. Time-limited generic paid and unpaid internships and apprenticeships for the development of employment skills, and

7. Time-limited participation in Project Search, or similar programs approved by the DDA.

D. Community Development Services can be provided in a variety of community settings and activities that promote opportunities for increased independence and inclusion. Through the person-centered planning process, all opportunities should be explored based on the person's preferences and support their desired outcomes and goals. The setting should not have institutional qualities. Considering the person's overall PCP, activities should not isolate or segregate. If the individual chooses any disability specific classes, activities, events or programs, the choice must be documented in the PCP.

E. Community Development Services include:

1. Provision of direct support services that enable the participant to learn, develop, and maintain general skills related to participation in community activities as provided in Sections A-C above;

2. Transportation to, from, and within this Medicaid waiver program service;

3. Delegated nursing tasks or other Nursing Support Services covered by this Medicaid waiver program based on assessed need; and

4. Personal care assistance, based on an assessed need and subject to limitations set forth below.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary school.

B. The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program must be based on the participant's assessed level of service need.

1. Based on the participant's assessed need, the DDA may authorize a 1:1 and 2:1 staff-to-participant ratio;

2. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participant ratio:

a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio necessary 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 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.

d. 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.

C. Community Development Services are separate and distinct from residential services.

1. Participants may return home or to the provider-operated site during time-limited periods of the day to participate in supports provided virtually or due to lack of accessible restrooms and public areas to support personal care, health, emotional, and behavioral needs as indicated in the participant's file and service implementation plan.

2. Supports provided virtually can happen in the home or a licensed residential setting when the participant does not need paid direct support.

3. Residential and Personal Support Services cannot be billed during these times.

D. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

E. For participants enrolled in the Self-Directed Services Delivery Model, this Medicaid waiver program service includes:

1. The reasonable and customary costs of training the participant's direct support staff, including First Aid and Cardiopulmonary Resuscitation (CPR) certifications;

2. Travel reimbursement, benefits, and leave time for the participant's direct support staff, are subject to the following requirements:

a. The reimbursement, benefits and leave time requested are:

i. Within applicable reasonable and customary standards as established by the DDA policy; or

ii. Required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws; and

b. Any reimbursement, travel reimbursement (e.g., mileage), benefit and leave time requested by the participant must comply with applicable federal, State, or local laws.

c. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the Self-Directed Services Delivery Model, to the owner of a specialized, modified, or accessible vehicle driven by an employee of the participant and for the purpose of the participant engaging in activities specified in the recipient's Person-Centered Plan of service.

F. Service may be provided in a group of up to 4 participants, all of whom have similar interests and goals as outlined in their PCP, unless it is to participate in a time-limited internship through Project Search, or a similar program approved by the DDA.

G. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The Provider or participants self-directing their services must:

a. Provide, or arrange for provision of transportation to meet the needs of the participant as identified in the participant's file;

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

c. Transportation services may not compromise the entirety of this Medicaid waiver program service.

H. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program service; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Medicaid waiver program service.

I. An individualized schedule is required to provide an estimate of what the participant will do and where the participant will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires, and circumstances of the participant. The individualized schedule will be based on a PCP that clearly outlines how this time would be used.

J. A legally responsible person, legal guardian, or a relative (who is not a spouse) of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

K. 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.

1. These efforts must be documented in the participant’s file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

L. Community Development Services are not available at the same time as the direct provision of Career Exploration, Community Living—Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Services, Medical Day Care, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

M. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and of avoiding institutionalization.

N. Nursing Support Services, as applicable, can be provided during activities so long as it is not the primary or only service provided. The scope of the Nursing Support Services are defined under the stand-alone service in Appendix C.

O. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant’s health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by the DDA’s Regional Office and additional standalone Nursing Support Services hours can be authorized.

P. Direct Support Professional staffing services may be provided in an acute care hospital for the purposes of supporting the participant’s personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary Waiver services:

a. Must be identified in the participant’s file;

b. Must be provided to meet the participant’s needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the participant’s functional abilities.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SERVICE DEFINITION CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS

Q. Virtual Supports

1. Virtual supports is an electronic method of service delivery.

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including HIPAA, as amended by the HITECH Act, and their applicable regulations to protect the privacy and security of the participant's protected health information;

3. Supports provided virtually support a participant to reach identified outcomes in their PCP.

4. Supports provided virtually may not be used for the provider's convenience.

5. This Medicaid waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Medicaid waiver program service.

7. Supports provided virtually cannot be used to assess a participant for a medical emergency.

8. The participant and provider, as applicable, must have written policies, train direct support staff on those policies, and advise people 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.

9. MDH-licensed providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. For participants enrolled in the self-directed service delivery model using individual providers to provide a Medicaid waiver program service through virtual supports, they must include it as a service delivery method in their provider service implementation plan or job description.

11. 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.

R. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

****
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Development Services may not exceed a maximum of 8 hours per day or 40 hours weekly, including in combination with any of the following other Medicaid waiver program services in a single day: Employment Services – Job Development, Career Exploration, and Day Habilitation Services.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Development Services Provider
Individual	Community Development Services Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Development Services

Provider Category:

Agency

Provider Type:

Community Development Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability community engagement services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Community Development Services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

N. All providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;

O. Have a signed Medicaid Provider Agreement;

P. Have documentation that all vehicles used in the provision of services have automobile insurance; and

Q. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Satisfactorily complete necessary pre/in-service training based on the PCP;

5. Satisfactorily complete required orientation and training designated by the DDA;

6. Unlicensed direct support professional staff who administer medication or perform delegatable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH - for approval of Community Development Services Provider

2. Provider for verification of individual staff member's licenses, certifications, and training, as applicable

3. Financial Management and Counseling Services providers, as described in Appendix E.

Frequency of Verification:

1. MDH – Initially and annually.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Development Services

Provider Category:

Individual

Provider Type:

Community Development Services Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

5. Possess a valid driver’s license if the operation of a vehicle is necessary to provide services;

6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

7. Satisfactorily complete required orientation and training designated by DDA;

8. Satisfactorily complete necessary pre/in-service training based on the PCP;

9. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

10. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

11. Complete and sign any agreements required by the Maryland Department of Health or DDA; and

12. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above. They do not need to complete the DDA provider application. Individuals must submit forms and documentation as required by the Financial Management and Counseling Services agency. Financial Management and Counseling Services must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Community Development Services Professional.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services providers provider - Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living - Enhanced Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

A. Community Living - Enhanced Supports provides the participant, who exhibits challenging behaviors or has court ordered conditions for release or probation, with development, acquisition, and maintenance of skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, by providing additional observation and direction in a community residential setting.

B. Skills to be developed, acquired, or maintained under this service will be determined based on the participant's individualized goals and outcomes as documented in their file.

C. Formal teaching methods are used such as systematic instruction.

D. This service provides additional observation and direction to address the participant's documented challenging behaviors or court ordered conditions for release or probation.

E. This service includes Nursing Support Services and Behavioral Support Services as noted in the stand-alone services. The scope of the Nursing Support Services and Behavioral Support Services are defined under the stand-alone service in Appendix C.

F. This service will provide the participant with opportunities to develop skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, including:

1. Learning socially acceptable behavior;

2. Learning effective communication;

3. Learning self-direction and problem solving;

4. Engaging in safety practices;

5. Performing household chores in a safe and effective manner;

6. Performing self-care; and

7. Learning skills for employment.

G. Community Living - Enhanced Supports services include coordination, training, mentoring, supports, or supervision (as indicated in the participant's file) related to development or maintenance of the participant's skills, particularly pertaining to remediating the participant's challenging behaviors.

H. This Medicaid waiver program service includes provision of:

1. Direct support services, for provision of services as provided in Sections A-G above; and

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation to and from and within this Medicaid waiver program service;

b. Delegated nursing tasks or other Nursing Support Services covered by this Medicaid waiver program, based on the participant's assessed need;

c. Behavioral Support Services, based on the participant's assessed needs;

d. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older.

B. Participants must be preauthorized by the DDA based on documented level of supports needed.

C. 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.

D. The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's assessed level of service need.

1. Based on the participant's assessed needs, the DDA may authorize dedicated hours for 1:1 and 2:1 staff-to-participant supports.

2. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participant ratio:

a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio necessary 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 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 up to 6 months while a Behavior Support Plan gets authorized and developed.

d. 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.

E. The following criteria will be used to determine if the participant has an assessed need for Community Living – Enhanced Supports Services:

1. The participant has critical support needs that cannot be met by other residential or in-home services and supports; and

2. The participant meets the following criteria:

a. The participant has (i) court ordered restrictions to community living; (ii) demonstrated history of severe behaviors requiring restrictions and the need for enhanced skills staff; or (iii) extensive needs; and

b. Community Living – Enhanced Support Services are provided in the most integrated environment to meet the participant's needs.

F. Under this Medicaid waiver program service, the participant's primary residence must meet the following requirements:

1. This Medicaid waiver program service must be provided in a group home setting, owned, or operated by the provider.

2. No more than four participants may receive this Medicaid waiver program service in a single residence, unless previously approved by the DDA.

3. 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 CFR § 441.301(c)(4), as amended.

4. Each participant receiving this Medicaid waiver program service must be provided with a private, single occupancy bedroom.

G. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The Provider must:

a. Provide, or arrange for provision of transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation.

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

H. If direct support staff perform delegated nursing tasks as part of this Medicaid Waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program service; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Medicaid waiver program service.

I. If direct support staff provide behavioral supports as part of this Medicaid waiver program service, then:

1. The participant must receive Behavioral Support Services under this Medicaid waiver program service; and

2. The behavioral supports:

a. Must be provided by direct support who have received training in the participant's Behavior Support Plan; and

b. May not compromise the entirety of this Medicaid waiver program service.

J. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

K. The provider must have an organizational structure that ensures services are available at each licensed site on a 24-hour, 7-day a week basis, including back-up and emergency support, in accordance with staffing requirements set forth in each participant's file.

L. Community Living – Enhanced Support trial experience is for people transitioning from an institutional or non-residential site on a temporary, trial basis, and meets the following criteria:

1. Service must be preauthorized by the DDA.

2. Services may be provided for a maximum of 7 days or overnight stays within the 180-day period in advance of their move.

3. When services are furnished to participants returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver.

4. The individual must be reasonably expected to be eligible for and to enroll in the waiver. Services are billed to Medicaid as an administrative cost.

M. The Medicaid payment for Community Living - Enhanced Supports may not include either of the following items which the provider is expected to collect from the participant:

1. Room and board; or

2. Any assessed amount of contribution by the participant for the cost of care.

N. Residential Retainer Fee is available for up to 18 days per calendar year, per recipient, when the recipient is unable to receive services due to hospitalization, behavioral respite, or family/friend visits.

O. Community Living-Enhanced Supports services shall be provided for at least 6 hours a day to a participant or overnight when the participant spends the night in the residential home.

P. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by the DDA's Regional Office and additional standalone Nursing Support Services hours can be authorized.

Q. 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, MSDE, DORS, DHS, and any other federal or State government funding program, must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

R. Community Living - Enhanced Supports services are not available at the same time as the direct provision of Behavioral Support Services, Career Exploration, Community Development Services, Community Living-Group Home, Day Habilitation, Employment Services, Medical Day Care, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

S. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

T. 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.

******CONTINUED BELOW DUE TO SPACING LIMITATIONS**********

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**********CONTINUED FROM ABOVE DUE TO SPACING LIMITATIONS**********

U. Direct Support Professional services may be provided in an acute care hospital for the purposes of supporting the participant's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary waiver services:

a. Must be identified in the individual's file;

b. Must be provided to meet the individual's needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserve the participant's functional abilities.

V. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

**********Specify applicable (if any) limits on the amount, frequency, or duration of this service:******

1. Community Living – Enhanced Supervision Residential Retainer Fee is limited to up to 18 days per calendar year, per participant per provider.

2. Community Living – Enhanced Support trial experience is limited to a maximum of 7 days or overnight stays per provider.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living - Enhanced Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living - Enhanced Supports

Provider Category:

Agency

Provider Type:

Community Living - Enhanced Supports Provider

Provider Qualifications

License *(specify):*

Licensed DDA Residential Enhanced Supports Provider

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

A. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

B. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

C. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability residential services;

D. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

E. Demonstrate the capability to provide or arrange for the provision of all Community Living – Enhanced Services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Community Living – Enhanced Supports;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

K. Be in good standing with the IRS and SDAT;

L. Satisfactorily complete required orientation and training designated by DDA;

M. Satisfactorily complete necessary pre/in-service training based on the PCP;

N. Have Workers' Compensation Insurance;

O. Have Commercial General Liability Insurance;

P. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a.

Q. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

R. Comply with the DDA standards related to provider qualifications;

S. Have an organizational structure that assures services for each residence as specified in the PCP and the availability of back-up and emergency support 24 hours a day; and

T. Complete and sign any agreements required by the Maryland Department of Health or DDA.

U. Be licensed by the OHCQ;

V. Meet and comply with the federal community settings regulations and requirements prior to enrollment;

W. Have a signed Medicaid provider agreement;

X. Have documentation that all vehicles used in the provision of services have automobile insurance; and

Y. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is

good for up to a 3 year period.

Staff working for or contracted with the agency, as well as volunteers, utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

A. Be at least 18 years old;

B. Have required credentials, license, or certification as noted below;

C. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

D. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

E. Complete necessary pre/in-service training based on the PCP;

F. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

G. Complete required orientation and training designated by DDA;

H. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

I. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

In addition to the DDA mandated training, direct support staff must be trained in:

A. Person-Centered Planning;

B. Working with people with behavioral challenges;

C. Trauma informed care;

D. De-escalation; and

E. Physical management.

Based on the needs of the participants, the following additional training will be required for direct support staff:

A. Working with Sex Offenders;

B. Working with people in the criminal justice system; and/or

C. Working with the Community Forensics Aftercare program.

Agency must contract or employ LBA, Board Certified Behavioral Analysis (BCBA), Psychologist, or Licensed Clinician (LCPC, LCSW-C, LGPC, LMSW) on staff that has experience in the following areas:

A. Working with deinstitutionalized individuals;

B. Working with the court and legal system;

C. Trauma informed care;

D. Behavior Management;

E. Crisis management models; and

F. Counseling.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of provider license and licensed site.

2. Provider for verification of certifications, credentials, licenses, staff training and experience.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Discovery and Customization (phased out effective years 3, 4, and 5)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Employment Discovery and Customization services are time limited services to identify and develop customized employment options for participants working towards competitive integrated employment or self-employment.

B. Employment Discovery is a time-limited comprehensive, person-centered, community-based employment planning process. The Employment Discovery process and activities include:

1. Completing assessment and employment-related profiles in a variety of community settings;

2. Assessment of the community surrounding the participant's home;

3. Work skills and interest inventory;

4. Community-based job trials and community-based situations in order to identify skills, interest, and learning style;

5. Identification of the ideal conditions for employment for the participant which may include self-employment; and

6. Development of an Employment Discovery Profile with all pertinent information about the participant's skills, job preferences, possible contributions to an employer, and useful social networks. The profile may also include a picture or written resume.

C. Customization is support to assist a participant to obtain a negotiated competitive integrated job or self-employment. The Customization process and activities include:

1. The use of the participant's social network, community resources and relationships, the American Job's Centers, and provider business contacts to identify possible employers.

2. Flexible strategies designed to assist in obtaining a negotiated competitive integrated job including: (a) job development, (b) job carving, (c) job sharing, (d) self-employment; and other national recognized best practices, based on the needs of both the job seeker and the business needs of the employer.

D. Employment Discovery and Customization does not include volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited.

E. This Waiver program service includes provision of:

1. Direct support services, for provision of services as provided in Sections A-C above; and

2. The following services provided in combination with, and incidental to, the provision of this Wavier program service:

a. Transportation to and from and within this Waiver program service;

b. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary school.

B. Employment Discovery and Customization services and supports are provided for participants wanting to work in competitive integrated jobs paid by a community employer or through self-employment.

C. Until the service transitions to the LTSSMaryland system, under the traditional service delivery model, a participant's PCP may include a mix of employment and day related daily Waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Supported Employment Services provided on different days.

D. Beginning July 1, 2020, a participant's PCP may include a mix of employment and day related hourly Waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Employment Services provided at different times.

E. If transportation is provided as part of this Waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Waiver program service;

2. The Provider must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's PCP; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation services may not compromise the entirety of this Waiver program service.

F. If personal care assistance services are provided as part of this Waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

G. Until the service transitions to the LTSSMaryland system, Employment Discovery and Customization daily services units are not available:

1. On the same day a participant is receiving Career Exploration, Community Development Services, Day Habilitation, Medical Day Care, or Supported Employment services under the Traditional Services Delivery Model; and

2. At the same time as the direct provision of Behavioral Support Services, Community Living—Enhanced Supports, Community Living-Group Homes, Nursing Support Services, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by Maryland Medicaid State Plan, MSDE, DORS, and DHS or any other federal, or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's PCP. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program.

I. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

J. Documentation must be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 USC 1401 et seq.).

K. A legally responsible person, relative, or legal guardian of the participant cannot be paid by the Waiver program, either directly or indirectly, to provide this Waiver program service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Employment Discovery and Customization activities must be completed within a 6 month period unless otherwise authorized by the DDA.

2. Employment Discovery and Customization services may not exceed a maximum of 8 hours per day or 40 hours per week, including in combination with any of the following other Waiver program services in a single day: Supported Employment, Career Exploration, Community Development Services, and Day Habilitation services.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Discovery and Customization Provider
Individual	Employment Discovery and Customization Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Discovery and Customization (phased out effective years 3, 4, and 5)

Provider Category:

Agency

Provider Type:

Employment Discovery and Customization Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Except for currently DDA licensed or certified Employment Discovery and Customization providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Employment Discovery and Customization services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and MDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

N. All new providers must meet and comply with the federal community settings regulations and requirements;

O. Have a signed Medicaid Provider Agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as CQL or CARF for similar services for individuals with developmental disabilities, and be in good standing with the IRS and MDAT.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below;

3. Possess current First Aid and CPR certification;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Complete necessary pre/in-service training based on the PCP;

6. Complete required orientation and training designated by DDA;

7. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of provider to provide service.

2. Provider for verification of individual staff members' licenses, certifications, and training.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Discovery and Customization (phased out effective years 3, 4, and 5)

Provider Category:

Individual

Provider Type:

Employment Discovery and Customization Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Possess current First Aid and CPR certification;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

5. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

6. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

7. Complete required orientation and training designated by the DDA;

8. Complete necessary pre/in-service training based on the PCP;

9. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;

10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;

11. Complete and sign any agreements required by the MDH or DDA; and

12. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for the approval of the certified professional.

2. FMCS provider, as described in Appendix E, for participant's self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Employment Services are designed to assist individuals identify, obtain, and maintain competitive and integrated employment positions within their community. Employment Services provides the participant with a variety of flexible supports to help the participant to identify career and employment interest, find and keep a job including:

1. Discovery – a process to assist the participant in finding out who they are, what they want to do, and what they have to offer;

2. Job Development – supports finding a job including customized employment and self-employment;

3. Ongoing Job Supports – various supports a participant may need to successfully maintain and advance their job. This

includes Nursing Support Services based on assessed need. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C;

4. Follow Along Supports – periodic supports after a participant has transitioned into their job;

5. Self-Employment Development Supports – supports to assist a participant whose discovery activities and profile indicate a specific skill or interest that would benefit from resource ownership or small business operation; and

6. Co-Worker Employment Support-supports in a situation when an employer has identified that an onsite job coach would not be optimal, yet the participant could still benefit from additional supports.

B. Discovery is a time limited, comprehensive, person-centered, and community-based employment planning support service to assist the participant to identify the participant's abilities, conditions for success, and interests.

Discovery includes:

1. A visit to a participant's home and/or community location, a review of community employers, job trials, interest inventory to create a profile and visual resume that includes the use of images and graphics to highlight a job seeker's skills and abilities;

2. The development of a Discovery Profile; and

3. An Employment Plan including a summary of all activities completed during the Discovery process, a visual resume, and a documentation of next steps and action items.

C. Job Development is support for a participant to obtain an individual job or explore new employment alternatives in a competitive integrated employment setting in the general workforce, including:

1. Customized employment – a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both. It is based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer;

2. Self-employment – including exploration of how a participant's interests, skills and abilities might be suited for the development of business ownership; and

3. 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.

D. 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.

7. Direct support can be provided via remote technology (for example: Skype or Facetime) if preferred by the participant and outlined in their Person-Centered Plan. This support must still meet DDA billing requirements.

E. Follow Along Supports:

1. Occurs after the participant has transitioned into their competitive integrated employment job.

2. Ensure the participant has the assistance necessary to maintain their jobs; and

3. 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:

a. Phone calls to the person and/or employer; and

b. General coordination needed to support a person to maintain their employment.

4. Direct support contacts are not required to take place at the employment site if this is a preference of the participant and/or the employer.

5. Direct support contacts can be completed using virtual supports as indicated in the person's person-centered plan (for example: Skype or Facetime) if preferred by the person and outlined in the person's Person-Centered Plan.

F. Self-Employment Development Supports include assistance in the development of a business and marketing plan, including potential sources of business financing and other assistance in developing and launching a business. The completion of a business and marketing plan does not guarantee future funding to support a business outlined in the plans.

G. Co-Worker Employment Supports are time-limited supports provided by the employer to assist the participant, upon employment, with extended orientation and training beyond what is typically provided for an employee.

H. Employment Services does not include:

1. Volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited; and

2. Payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.

I. This Medicaid waiver program service includes provision of:

1. Direct support services, for provision of services as provided in Sections A-G above;

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation to, from, and within this Medicaid waiver program service;

b. Delegated nursing tasks or other Nursing Support Services covered by this Medicaid waiver program, based on the participant’s assessed need; and

c. Personal care assistance, based on the participant’s assessed need.

J. Competitive Integrated Employment (CIE) means a position that has competitive wages and the same opportunities for advancement and benefits as individuals without a disability and requires that the individual work in an integrated location.

1. When seeking service authorization and/or re-authorization for Employment Services through Follow-Along Job Supports and/or Ongoing Job Supports, a person’s job must have the qualities of competitive integrated employment. This means the position should have:

a. Competitive wages- minimum wage or above;

b. Integrated location; and

c. Same opportunities for advancement and benefits as other employees.

2. Whether a position constitutes competitive integrated employment will be considered on a case by case basis. The position may or may not be approved depending on the job characteristics and the quality of the person's experience.

3. The person-centered planning team shall use the Competitive Integrated Employment Checklist to assess whether an employment position has the qualities of competitive integrated employment.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older and no longer enrolled in primary or secondary high school.

B. Discovery includes 3 distinct milestones. Best practices demonstrate that quality person-centered discovery milestones can typically be completed within 90 days. However, the completion of each milestone is flexible and will be considered in conjunction with the participant's unique circumstances.

C. Each discovery milestone must be completed as per DDA standards with the documented evidence of completion of the required activities before being paid.

D. Discovery activities shall be reimbursed based on the following milestones and standards:

1. Milestone #1 –

a. 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;

b. Documentation that the visit included discussion of the participant's interests and preferred activities or hobbies, including how they spend their time;

c. An in-person survey of the community near and around the participant's home;

d. Record reviews for pertinent job experience, education, assessments;

e. Documentation of other collaboration with other pertinent team members; and

f. Completion of Discovery Milestone #1 Profile.

2. Milestone #2 – includes:

a. An individualized skill assessment, learning and teaching style identification through community-based task trials;

b. A minimum of three (3) job trials and/or community skills observation; and/or informational interviews with area employers;

c. Documentation of what has emerged and what was learned from the job trials, community skills observations, and informational interview;

d. Documentation of team discussions and coordination; and

e. Completion of Discovery Milestone #2 Profile.

3. Milestone #3 – includes:

a. Compilation of information collected to-date, any additional activities that have occurred within Discovery;

b. A final summary outlining who the participant is;

c. Written and/or visual resume;

d. 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

e. Completion of Discovery Milestone #3 Profile.

E. Job Development is reimbursed based on 15-minute increments.

F. Ongoing Job Supports is reimbursed based on 15-minute increments and includes a “fading plan”, when appropriate, that notes the anticipated number of support hours needed.

G. Follow Along Supports are reimbursed as one monthly payment.

H. Self-Employment Development Supports shall be reimbursed based on one milestone for the completion of a business and marketing plan.

I. Employment Services must be provided by staff who have the appropriate proof of competency required as outlined in the DDA Meaningful Day Training Policy.

J. Participants, not currently receiving Ongoing Job Supports, that are promoted with new job tasks or changes positions or circumstances, can receive Ongoing Job Supports.
**********CONTINUED IN MAIN-OTHER
****

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Discovery services are limited to once every 2 years.

2. Job Development services cannot exceed 8 hours per day.

3. Job Development services cannot exceed a total maximum of 90 hours per plan year.

4. Job Development services may not exceed a maximum of 40 hours per week including in combination with any of the following other Medicaid waiver program services in Meaningful Day Services (e.g., Community Development Services, Career Exploration, and Day Habilitation services).

5. Co-Worker Employment Supports are limited to the first three months of employment.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Service Provider
Individual	Employment Services Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Services

Provider Category:

Agency

Provider Type:

Employment Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability employment services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Employment Services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. Be in good standing with the IRS and SDAT;

F. Have Workers' Compensation Insurance;

G. Have Commercial General Liability Insurance;

H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. Satisfactorily complete required orientation and training designated by DDA;

K. Comply with the DDA standards related to provider qualifications; and

L. Complete and sign any agreements required by the MDH or DDA.

2. All providers must meet and comply with the federal community settings regulations and requirements;

3. Have a signed Medicaid Provider Agreement;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

4. Have a DDA approved certification in employment to provide discovery services;

5. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the MBON as Medication Technicians;

6. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

7. Satisfactorily complete necessary pre/in-service training based on the PCP;

8. Satisfactorily complete required orientation and training designated by the DDA;

9. Possess a valid driver’s license if the operation of a vehicle is necessary to provide services; and

10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of providers.

2. Employment Service Professional for verification of staff standards.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Services

Provider Category:

Individual

Provider Type:

Employment Services Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have DDA required credentials, license, or certification;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Have a DDA approved certification in employment to provide discovery services;

6. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the MBON as Medication Technicians, except if the participant and their medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;

7. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services;

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

9. Satisfactorily complete required orientation and training designated by the DDA;

10. Satisfactorily complete necessary pre/in-service training based on the PCP;

11. Have 3 professional references which attest to the provider’s ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

12. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

13. Complete and sign any agreements required by the MDH or DDA; and

14. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the certified Employment Services Professional.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to initial services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. An Environmental Assessment is an on-site assessment with the participant at their primary residence to determine if Environmental Modifications or Assistive Technology may be necessary in the participant's home.

B. Environmental Assessment includes:

1. An evaluation of the participant;

2. Environmental factors in the participant's home;

3. The participant's ability to perform activities of daily living;

4. The participant's strength, range of motion, and endurance;

5. The participant's need for Assistive Technology and or environmental modifications; and

6. The participant's support network including family members' capacity to support independence.

SERVICE REQUIREMENTS:

A. The assessment must be conducted by an Occupational Therapist licensed in the State of Maryland or a Division of Rehabilitation Services approved environmental assessment vendor.

B. The Occupational Therapist must complete an Environmental Assessment Service Report to document findings and recommendations based on an onsite Environmental Assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g., family, direct support staff, delegating nurse/nurse monitor, etc.).

C. The report shall:

1. Detail the Environmental Assessment process, findings, and specify recommendations for the home modification and Assistive Technology that are recommended for the participant;

2. Be typed; and

3. Be completed within 10 business days of the completed assessment and forwarded to the participant and their CCS in an accessible format.

D. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Waiver program.

E. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

F. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT 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 is to improve and maintain the ability of the child to remain in and engage in community activities.

G. A legally responsible person, relative, or legal guardian of the participant cannot be paid by the Waiver program, either directly or indirectly, to provide this Medicaid waiver program service.

H. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Environment Assessment is limited to 1 assessment annually, per plan year.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider
Individual	Environment Assessment Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the MDH to provide at least one Medicaid Waiver service; and

2. Complete the MDH provider application to be an OHCDS provider.

OHCDS providers shall:

1. Verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request; and

2. Obtain Workers Compensation if required by applicable law.

Environmental Assessment Professional requirements:

1. Employ or contract staff licensed by the Maryland Board of Occupational Therapy Practice as a licensed Occupational Therapist in Maryland or

2. Contract with a DORS approved vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH - for approval of the OHCDS.

2. OHCDS provider verification of Occupational Therapist (OT) License and DORS approved vendor.

Frequency of Verification:

1. MDH - Initially and at least every 3 years.

2. OHCDS - Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:

Individual

Provider Type:

Environment Assessment Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Be a licensed Occupational Therapist by the Maryland Board of Occupational Therapy Practice or a DORS approved vendor;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Have Commercial General Liability Insurance;

5. Satisfactorily complete required orientation and training designated by the DDA;

6. Satisfactorily complete necessary pre/in-service training based on the PCP;

7. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

8. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

9. Complete and sign any agreements required by the MDH or DDA; and

10. Have a signed Medicaid Provider Agreement.

Environmental Assessment Professional shall:

1. Be properly licensed by the State;

2. Be in good standing with the State Department of Assessments and Taxation to provide the service;

3. Maintain Commercial General Liability Insurance;

4. Obtain and maintain worker's compensation insurance sufficient to cover all employees, if required by law; and

5. Be bonded as is legally required.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the certified Environmental Assessment Professional.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – prior to initial services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Environmental Modifications are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence or to create a safer, healthier environment.

B. Environmental Modifications include:

1. The following types of Environmental Modifications:

a. Installation of grab bars;

b. Construction of access ramps and railings;

c. Installation of detectable warnings on walking surfaces;

d. Alerting devices for participant who has a hearing or sight impairment;

e. Adaptations to the electrical, telephone, and lighting systems;

f. Generator to support medical and health devices that require electricity;

g. Widening of doorways and halls;

h. Door openers;

i. Installation of lifts and stair glides (with the exception of elevators), such as overhead lift systems and vertical lifts;

j. Bathroom modifications for accessibility and independence with self-care;

k. Kitchen modifications for accessibility and independence;

l. Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; plexiglass, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;

m. Smart home devices that require attachment to the home, such as voice activated door openers, blinds and shade openers.

2. Training on use of modification; and

3. Service and maintenance of the modification.

C. Environmental Modifications do not include:

1. Improvements to the residence that:

a. Are of general utility;

b. Are not of direct medical or remedial benefit to the participant or otherwise meets the needs of the participant as defined in Sections A-B above;

c. Add to the home’s total square footage, unless the construction is necessary, reasonable, and directly related to the participant’s access to the participant’s primary residence; or

d. Are required by local, county, or State law when purchasing or licensing a residence;

2. A generator for use other than to support the participant’s medical and health devices that require electricity for safe operation; or

3. An elevator.

SERVICE REQUIREMENTS:

A. If an Environmental Assessment is required prior to authorization of Environmental Modification services, then it must be completed as per the Environmental Assessment services requirements.

1. If the estimated cost of the requested Environmental Modification is equal to or greater than $2,000, then the participant must receive an Environmental Assessment, performed in a reasonable amount of time prior to installation of an Environmental Modification.

2. If the estimated cost of the requested Environmental Modification is less than $2,000, then an Environmental Assessment is not required.

B. If the requested Environmental Modification is estimated to cost over $2,000 over a 12-month period, then the participant must provide at least 3 bids. The DDA may accept less than 3 bids due to lack of contractors.

C. If the requested Environmental Modification restricts the participant's rights, as set forth in Title 7 of the Health-General Article of the Maryland Annotated Code or COMAR Title 10, Subtitle 22, then the need for the restriction must be set forth 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.

D. For a participant to be eligible to receive Environmental Modification services funded by the Medicaid waiver program, either:

1. The participant is the owner of the primary residence; or

2. If the participant is not the owner of the primary residence, the property manager or owner of the primary residence provides in writing:

a. Approval for the requested Environmental Modification; and

b. Agreement that the participant will be allowed to remain in the primary residence for at least 1 year.

E. Deliverable Requirements:

1. Prior to installation, the provider must obtain any required permits or approvals from State or local governmental units for the Environmental Modification.

2. The provider must provide this Medicaid waiver program service in accordance with a written schedule that:

a. The provider provides to the participant and the CCS prior to commencement of the work; and

b. Indicates an estimated start date and completion date.

3. The provider must provide progress reports regarding work to the participant, the CCS, the Financial Management and Counseling Services provider, and the property owner, if applicable.

4. The provider must perform all work in accordance with applicable laws and regulations, including, but not limited to, the Americans with Disabilities Act and State and local building codes.

5. The provider must obtain any final inspections and ensure work passes required inspections.

6. Upon delivery to the participant (including installation) or maintenance performed, the Environmental Modification must be in good operating condition and repair in accordance with applicable specifications.

F. 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.

G. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

H. Environmental Modifications to support participants with new accessibility needs (e.g., grab bars, ramp, stair glide, etc.) to support health, safety, access to the home, and independence are available to participants receiving support services in residential models including Community Living—Enhanced Supports and Community Living-Group Home services.

I. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

J. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Cost of services must be customary, reasonable, and may not exceed a total of $50,000 every 3 years.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider
Individual	Environmental Modifications Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least 1 Medicaid Waiver service; and

2. Complete the MDH provider application to be an OHCDS provider.

OHCDS providers shall ensure the following requirements and verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request including:

1. Have a current license with the Maryland Home Improvement Commission or be a Division of Rehabilitation Services approved vendor;

2. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the OHCDS.

2. OHCDS provider for verification of the contractors and subcontractors to meet required qualifications.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. OHCDS – Contractors and subcontractors prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Environmental Modifications Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Have a current license with the Maryland Home Improvement Commission or be a Division of Rehabilitation Services approved vendor;

2. Complete and sign any agreements required by the MDH or DDA; and

3. Have a signed Medicaid Provider Agreement.

4. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the Environmental Modifications professional.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family and Peer Mentoring Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Family and Peer Mentoring Supports connect participants and their primary unpaid family caregivers with mentors who have lived similar experiences. These mentors provide invaluable support in navigating systems, local resources, and community services, while helping participants and families build knowledge, skills, and confidence to achieve their goals and live their best life.

B. Family and Peer Mentoring Supports fosters meaningful relationships and strengthens the resilience of both participants and their families through use of a mentor.

C. Family and Peer Mentoring Supports services encourage participants and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver participants and their families.

D. Family and Peer Mentoring Supports includes:

1. Facilitation of connection between:

i. The participant and the participant's relatives; and

ii. A mentor.

2. Follow-up support to assure the match between the mentor and the participant and the participant's relatives meets the participant's needs.

E. Family and Peer Mentoring Supports do not include the provision of any other Medicaid waiver services such as:

1. Provision of Coordination of Community Services;

2. Determination of participant eligibility for enrollment in the Medicaid waiver program, as described in Appendix B;

3. Development of the PCP, as described in Appendix D; or

4. Support Broker Services, as described in Appendices C and E.

SERVICE REQUIREMENTS:

A. Family and Peer Mentoring Supports are provided by DDA-approved Family and Peer Mentors. Family Mentoring is provided to the participant's primary unpaid caregiver while Peer Mentoring is provided to the participant.

B. Support needs for peer mentoring are identified in the participant's file.

C. The mentor can be an individual with developmental disabilities or the member of a family that includes an individual with developmental disabilities.

D. Mentors cannot mentor their own family members. 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.

1. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

E. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Peer and Family Mentoring Services are limited to 8 hours per day.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family and Peer Mentoring Provider
Individual	Family or Peer Mentor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Peer Mentoring Supports

Provider Category:

Agency

Provider Type:

Family and Peer Mentoring Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

A. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

B. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

C. A minimum of 5 years demonstrated experience and capacity with providing quality similar services such as self-advocacy and parent organizations;

D. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

E. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide mentoring services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

F. If currently licensed or approved produce upon written request from the DDA the documents required under D;

G. Be in good standing with the IRS and SDAT;

H. Have Workers' Compensation Insurance;

I. Have Commercial General Liability Insurance;

J. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a.

K. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

L. Satisfactorily complete required orientation and training designated by the DDA;

M. Comply with the DDA standards related to provider qualifications; and

N. Complete and sign any agreements required by the MDH or DDA.

1. Have a signed Medicaid provider agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Family Mentors must have lived experience in caring for and supporting a family member with intellectual and developmental disabilities to help them live their best life. They must have knowledge and firsthand experience in navigating and accessing State and local resources, supports, and services.

3. Peer Mentors must have an intellectual or developmental disability themselves, and they offer valuable insights from their own experiences, helping others access resources and supports to live their best life;

4. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

6. Satisfactorily complete necessary pre/in-service training based on the PCP;

7. Satisfactorily complete required orientation and training designated by the DDA;

8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the Family and Peer Mentoring Provider.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

3. Family and Peer Mentoring Provider for verification of staff standards.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Peer Mentoring Supports

Provider Category:

Individual

Provider Type:

Family or Peer Mentor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Family Mentors must have lived experience in caring for and supporting a family member with intellectual and developmental disabilities to help them live their best life. They must have knowledge and firsthand experience in navigating and accessing State and local resources, supports, and services.

3. Peer Mentors must have an intellectual and developmental disability themselves, and they offer valuable insights from their own experiences, helping others access resources and supports to live their best life;

4. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

6. Possess a valid driver’s license if the operation of a vehicle is necessary to provide services;

7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

8. Satisfactorily complete required orientation and training designated by the DDA;

9. Satisfactorily complete necessary pre/in-service training based on the PCP;

10. Have 3 professional references which attest to the individual's ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

11. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

12. Complete and sign any agreements required by the MDH or DDA; and

13. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the Family and Peer Mentors.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Caregiver Training and Empowerment Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

A. Family Caregiver Training and Empowerment Services provide education and support to the family caregiver of a participant that preserves the family unit and increases confidence, stamina, and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the file.

B. This service includes educational materials, training programs, workshops and conferences that help the family caregiver to:

1. Understand the disability of the person supported;

2. Achieve greater competence and confidence in providing supports;

3. Develop and access community and other resources and supports;

4. Develop or enhance key parenting strategies;

5. Develop advocacy skills; and

6. Support the person in developing self-advocacy skills.

C. Family Caregiver Training and Empowerment does not include the cost of travel, meals, or overnight lodging as per federal requirements.

SERVICE REQUIREMENTS:

A. Family Caregiver Training and Empowerment is offered only for a family caregiver who is providing unpaid support training, companionship, or supervision for a participant who is currently living in the family home.

B. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

C. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

D. 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.

E. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Family Caregiver Training and Empowerment Services are limited to a maximum of 10 hours of training for unpaid family caregivers per participant per plan year.

2. Educational materials, training programs, workshops, and conference registration fees for unpaid family caregivers are limited to up to $500 per participant per plan year.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family Support Professional
Agency	Organized Health Care Delivery System Provider
Agency	Parent Support Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Training and Empowerment Services

Provider Category:

Individual

Provider Type:

Family Support Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have a Bachelor’s Degree or demonstrated life experiences and skills to provide the service;

3. Satisfactorily complete required orientation and training designated by the DDA;

4. Have 3 professional references which attest to the provider’s ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

5. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

6. Complete and sign any agreements required by the MDH or DDA; and

7. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Family Support Professional.

2. Financial Management and Counseling Services provider, as described in Appendix E. for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services – Initially and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Training and Empowerment Services

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the Maryland Department of Health to provide at least one Medicaid Waiver service; and

2. Complete the MDH provider application to be an Organized Health Care Delivery System provider.

Organized Health Care Delivery System providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

Family Caregiver Training and Empowerment Services requirements:

1. Be at least 18 years old;

2. Have a Bachelor’s Degree; professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;

3. Satisfactorily complete necessary pre/in-service training based on the Person-Centered Plan;

4. Satisfactorily complete required orientation and training designated by the DDA

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Organized Health Care Delivery System.

2. Organized Health Care Delivery System providers for verification of entities and individuals they contract or employ.

Frequency of Verification:

1. Organized Health Care Delivery System – Initially and at least every 3 years.

2. Organized Health Care Delivery System Providers – prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Training and Empowerment Services

Provider Category:

Agency

Provider Type:

Parent Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity with providing quality developmental disability training services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, to produce, upon written request from the DDA, the documents required under D.

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training designated by the DDA;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

1. Have a signed Medicaid Provider Agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have a Bachelor's Degree; professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;

3. Satisfactorily complete necessary pre/in-service training based on the PCP;

4. Satisfactorily complete required orientation and training designated by the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Parent Support Agencies.

2. Parent Support Agency for verification of staff qualifications and requirements.

3. Financial Management and Counseling Services provider, as described in Appendix E. for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Parent Support Agency – Prior to service delivery and continuing.

3. Financial Management and Counseling Services – Initially and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Housing Support Services are time-limited supports to help participants to identify and navigate housing opportunities, address, or overcome barriers to housing, and secure and retain their own home.

B. Housing Support Services include:

1. Housing Information and Assistance to obtain and retain independent housing;

2. Housing Transition Services to assess housing needs and develop individualized housing support plan; and

3. Housing Tenancy Sustaining Services which assist the individual to maintain living in their rented or leased home.

C. Housing Information and Assistance includes:

1. Reviewing housing programs’ rules and requirements and their applicability to the participant;

2. Searching for housing;

3. Assistance with processes for applying for housing and housing assistance programs;

4. Assessing the living environment to determine it meets accessibility needs, is safe, and ready for move-in;

5. Requesting reasonable accommodations in accordance with the Fair Housing Act to support a person with a disability equal opportunity to use and enjoy a dwelling unit, including public and common use areas;

6. Identifying resources for security deposits, moving costs, furnishings, Assistive Technology, Environmental Modifications, utilities, and other one-time costs;

7. Reviewing the lease and other documents, including property rules, prior to signing;

8. Developing, reviewing, and revising a monthly budget, including a rent and utility payment plan;

9. Identifying and addressing housing challenges such as credit and rental history, obtaining an official form of identification card, criminal background, and behaviors; and

10. Assistance with resolving disputes.

D. Housing Transition Services includes:

1. Assisting the tenant during the screening and housing assessment including collecting information on potential housing barriers and identification of potential housing retention challenges;

2. Developing an individualized housing support plan that is incorporated in the participant's file that includes:

a. Short and long-term goals;

b. Strategies to address identified barriers including prevention and early intervention services when housing is jeopardized; and

c. Natural supports, resources, community providers, and services to support goals and strategies.

E. Housing Tenancy Sustaining Services assist the participant to maintain living in their rented or leased home, and includes:

1. Education and training on the role, rights and responsibilities of the tenant and landlord; how to be a good tenant; and lease compliance;

2. Coaching to develop and maintain key relationships with landlord/property manager and neighbors;

3. Assistance with housing recertification process;

4. Assistance with bill paying services (e.g., assistance with setting up and monitoring systems to pay rent, mortgage, utilities, and other related housing expenses).

5. Early identification and intervention for behaviors that jeopardize tenancy;

6. Assistance with resolving disputes with landlords and/or neighbors;

7. Advocacy and linkage with community resources to prevent eviction; and

8. Coordinating with the individual to review, update and modify the housing support plan.

F. Housing Support Services may be direct or indirect.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older.

B. A housing support plan must be completed in accordance with the following requirements:

1. The housing support plan must be incorporated into the participant's file.

2. The housing support plan must contain the following components:

a. A description of the participant's barriers to obtaining and retaining housing;

b. The participant's short and long-term housing goals;

c. Strategies to address the participant's identified barriers, including prevention and early intervention services when housing is jeopardized; and

d. Natural supports, resources, community-based service providers, and services to support the goals and strategies identified in the housing support plan.

C. The services and supports must be provided consistent with programs available through the U.S. Department of Housing and Urban Development, the Maryland Department of Housing and Community Development, and applicable federal, State, and local laws, regulations, and policies.

D. 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.

E. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

F. Virtual Supports

1. Virtual supports are an electronic method of service delivery.

2. Supports provided virtually must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including Health Insurance Portability and Accountability Act (HIPPA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH), and their applicable regulations to protect the privacy and security of the participant's protected health information.

3. Supports provided virtually must support a participant to reach identified outcomes in their Person-Centered Plan.

4. Supports provided virtually may not be used for the provider's convenience.

5. This Medicaid waiver program service may not be provided entirely via virtual supports. Supports provided virtually may supplement in-person direct supports.

6. Supports provided virtually must be delivered using a live, real-time audio-visual connection that allows the staff member to both see and hear the participant. Text messaging and emailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Medicaid waiver program service.

7. Supports provided virtually cannot be used to assess a participant for a medical emergency.

8. The provider and participants self-directing their services 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 person'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.

9. MDH-licensed providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22.

10. For participants self-directing who use individual providers to provide a Medicaid waiver program service through virtual supports, they must include it as a service delivery method in their provider service implementation plan or job description.

11. 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Housing Support Services are limited to 8 hours per day and may not exceed a maximum of 175 hours annually.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing Support Service Provider
Individual	Housing Support Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Housing Support Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality Housing Support Services to persons with developmental disabilities who successfully transitioned to independent renting;

C. Experience with federal affordable housing or rental assistance programs;

D. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

E. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant’s demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

F. Be in good standing with the IRS and SDAT;

G. Have Workers’ Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

1. Have a signed Medicaid Provider Agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have a GED or high school diploma;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Satisfactorily complete necessary pre/in-service training based on the PCP;

6. Satisfactorily complete required orientation and training designated by the DDA.

7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

9. Housing assistance staff minimum training requirements shall include:

(a) Conducting a housing assessment;

(b) Person-centered planning;

(c) Knowledge of laws governing housing as they pertain to individuals with disabilities;

(d) Affordable housing resources;

(e) Leasing processes;

(f) Strategies for overcoming housing barriers;

(g) Housing search resources and strategies;

(h) Eviction processes and strategies for eviction prevention;

(i) Tenant and landlord rights and responsibilities; and

(j) Creating personal budgets with individuals with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the provider.

2. Provider for verification of staff requirements.

3. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider - Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services – Prior to initial service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Individual

Provider Type:

Housing Support Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have GED or high school diploma;

3. Have satisfactorily completed training in the following:

A. Conducting a housing assessment;

B. Person-centered planning;

C. Laws governing housing as they pertain to individuals with disabilities;

D. Affordable housing resources;

E. Leasing processes;

F. Strategies for overcoming housing barriers;

G. Housing search resources and strategies;

H. Eviction processes and strategies for eviction prevention;

I. Tenant and landlord rights and responsibilities; and

J. Creating personal budgets with individuals with developmental disabilities.

4. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace;

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

6. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services;

7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

8. Satisfactorily complete required orientation and training designated by the DDA;

9. Satisfactorily complete necessary pre/in-service training based on the PCP;

10. Have 3 professional references which attest to the provider’s ability to deliver the support/service in compliance with the Department’s policy in Annotated Code of Maryland, Health General, Title 7;

11. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

12. Complete and sign any agreements required by the MDH or DDA; and

13. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of Housing Support Professional.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services – Prior to initial service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual and Family Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Individual and Family Directed Goods and Services (IFDGS) are services, equipment, activities, or supplies, for participants who self-direct their services, not otherwise provided through this Medicaid waiver program or through the Medicaid State Plan, that address an identified need in a participant's PCP, which includes improving and maintaining the participant's opportunities for full membership in the community. IFDGS enable the participant to maintain or increase independence and promote opportunities for the participant to live in and be included in the community.

B. IFDGS must meet the following criteria:

1. Relate to a need or goal identified in the PCP;

2. Are for the purpose of maintaining or increasing independence;

3. Promote opportunities for community living, integration, and inclusion;

4. Are able to be accommodated without compromising the participant's health or safety; and

5. Are provided to, or directed exclusively toward, the benefit of the participant.

C. IFDGS includes dedicated funding up to $500 that participants may choose to use for costs associated with staff recruitment and advertisement efforts such as developing and printing flyers and using staffing registries.

D. IFDGS decrease the need for Medicaid services, increase community integration, increase the participant's safety in the home, or support the family in the continued provision of care to the participant.

E. The goods and services may include:

1. Activities that promote fitness, such as fitness membership, personal training, aquatics, and horseback riding;

2. Fees for community programs and activities that are inclusive, promote socialization and independence, such as art, music, dance, sports, or other according to the participant's individual interests;

3. Small kitchen appliances that promote independent meal preparation, if the participant lives independently;

4. Laundry appliances (non-commercial washer and/or dryer), if none exist in the home, to promote independence and self-care, if the person lives independently;

5. Sensory items related to the person's disability, such as headphones and weighted vests;

6. Safety equipment related to the person's disability and not covered by health insurance, such as protective headgear and arm guards;

7. Personal electronic devices, including watches and tablets, to meet an assessed health, communication, or behavioral purpose documented in the PCP;

8. Fitness items that can be purchased at most retail stores not to exceed $1,000 per item;

9. Toothbrushes or electric toothbrushes related to the person's disability and not covered by insurance;

10. Weight loss program services other than food related to the person's disability, recommended by a medical professional, and not covered by health insurance;

11. Dental services recommended by a licensed dentist and not covered by health insurance such as dental anesthesia and denture services not covered by health insurance;

12. Nutritional consultation and supplements recommended by a professional licensed in the relevant field related to the person's disability and not covered by health insurance; and

13. Initial startup costs (purchase of modem or other startup) for internet services; and

14. Day-to-Day Administrative Supports that provide assistance with participant's household management and scheduling medical appointments. Household management includes the coordination of essential care and repair of the premises for the following:
a. Scheduling house maintenance (e.g. furnace checks) and repairs (e.g. dishwasher repair);
b. Scheduling snow removal; and
c. Scheduling lawn care.

F. Experimental or prohibited goods and treatments are excluded.

G. IFDGS do not include the following services, activities, goods, or items:

1. Services, goods or supports provided to or directly benefiting persons other than the participant that have no benefit to the participant;

2. Otherwise covered by the Medicaid waiver program or the Medicaid State Plans;

3. Additional units or costs beyond the maximum allowable for any Medicaid waiver program service or Medicaid State Plan, with the exception of a second wheelchair;

4. Co-payment for medical services, over-the-counter medications, or homeopathic services;

5. Items used for entertainment or recreational purposes, such as televisions, video recorders, game stations, and DVD player except as needed to meet an assessed behavioral or sensory need documented in a Behavior Support Plan;

6. Monthly cable fees;

7. Monthly telephone fees;

8. Room & board, including deposits, rent, and mortgage expenses and payments;

9. Food;

10. Utility charges;

11 Fees associated with telecommunications;

12. Tobacco products, alcohol, cannabis, or illegal drugs;

13. Vacation expenses and travel adventures;

14. Insurance; vehicle maintenance or any other transportation- related expenses;

15. Tickets, memberships, and related cost to attend recreational activities and events, such as museums, zoos, bowling, and indoor skydiving;

16. Personal clothing and shoes;

17. Haircuts, nail services, and spa treatments;

18. Goods or services with costs that exceed reasonable and customary costs for the same or similar good or service;

19. Tuition including:
a. Post-secondary credit and noncredit courses;
b. Tuition and educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA);
c. Tuition and other fees associated with programs or activities at educational institutions;
d. Private tuition;
e. Applied Behavior Analysis (ABA) in schools; and
f. School supplies, tutors, and home-schooling activities and supplies.

20. Staff bonuses and staff benefits;

21. Housing subsidies;

22. Subscriptions;

23. Training provided to paid caregivers;

24. Services in hospitals;

25. Costs of travel, meals, and overnight lodging for staff, families, and natural support network members to attend a training event or conference;

26. Service animals and associated costs;

27. Exercise rooms, swimming pools, and hot tubs and all associated cost and accessories;

28. Fines, debts, legal fees or advocacy fees;

29. Contributions to ABLE Accounts and similar saving accounts;

30. Country club membership or dues;

31. Leased or purchased vehicles and all associated cost and accessories;

32. Items purchased prior to the approved PCP; including items purchased prior to DDA approval of the Individual and Family Goods and Services request;

33. Goods, services, equipment, and supplies intended for commercial use, such as commercial washers and dryers;

34. Goods, services, equipment, and supplies that are diversional or recreational in nature fall outside the scope of section Medicaid 1915(c) of the Social Security Act;

35. Goods, services, equipment, and supplies that a household that does not include a person with a disability would be expected to pay for as household expenses (e.g., subscription to a cable television service); and

36. Programs and activities that are exclusive for individuals with disabilities.

37. Day-to-Day Administrative Supports does not include:

a. Making payments for household management care including repairs, snow removal, and lawn care.
b. Making decisions for the participant;
c. Approving and signing timesheets or vendor/provider invoices;
d. 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;
e. Developing staffing schedules and cleaning schedules which can be supported by team members, Support Brokers, and Personal Support Services staff;
f. Financial management such as:
i. Maintaining benefits and Medicaid eligibility (e.g. food stamps, Medicaid waiver, etc.) that can be supported by Coordinators of Community Services, Benefits Counselors, and other resources;
ii. Managing money and property management which can be provided by a guardian of property or representative payee. A guardian of property is someone the court names to manage money and property for someone else whom the court has found cannot manage their money and property alone. A representative payee, often shortened to "rep payee," is an individual or organization appointed by the Social Security Administration (SSA) to receive and manage Social Security or Supplemental Security Income (SSI) benefits on behalf of a beneficiary who is unable to manage their own finances.;
g. Development of a Person-Center Plan, emergency plan, or staffing back-up plan which is directed by the participant and their legally authorized representative, facilitated by the Coordinator of Community Services, and with support of the team including Support Brokers.
h. Assistance with recruiting and hiring direct support professionals, managing workers, terminating workers, and providing information on effective communication, problem-solving, and conflict resolution which is provided with Support Brokers Services; and
i. Monitoring of participant’s services, activities, goals, and satisfaction which is determined by the participant and assessed quarterly or more frequently by the Coordinator of Community Services with input from the participant’s team.

SERVICE REQUIREMENTS:

A. Participant, legal guardian or the designated representative self-directing services on behalf of the participant make

decisions on goods and services based on an identified need in the PCP.

B. IFDGS must meet the following requirements:

1. The item or service would decrease the need for other Medicaid services; OR

2. Promote inclusion in the community; OR

3. Increase the participant's safety in the home environment; AND

4. The participant does not have the funds to purchase the item or service; AND

5. The item or service is not available through another source.

C. IFDGS are purchased from the participant-directed annual budget allocation and must be documented in the participant's record.

D. IFDGS must be clearly noted and linked to an assessed participant need established in the PCP.

E. The goods and services, except for $500.00 for recruitment activities, must fit within the participant's annual budget allocation without compromising the participant's health and safety. IFDGS are purchased from the savings identified and available in the participant's annual budget in accordance with the following requirements:

1. Except for $500 per year for costs associated with recruitment of staff, the DDA will not authorize additional funding for IFDGS in the participant's annual budget.

2. The participant must identify savings in the participant's annual budget to be used to purchase IFDGS.

3. The identified savings may not be used if doing so would deplete the participant's annual budget in a manner that compromises the participant's health or safety.

4. The services, equipment, activities, or supplies to be purchased pursuant to this Medicaid waiver program service must be documented in the participant's PCP and authorized by the DDA or its designee.

**********CONTINUED IN MAIN-B BELOW DUE TO SPACE LIMITATIONS**********

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individual and Family Directed Goods and Services requests are limited to $5,500 per year from the total self-directed budget of which $500 is dedicated to support staff recruitment efforts such as developing and printing flyers and using staffing registries.

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.

Day-to-Day Administrative Supports must be reasonable and may be provided up to 10 hours per month.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual and Family Directed Goods and Services

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A. Agencies must meet the following standards:

1. Be approved by the DDA to provide at least one Medicaid waiver service; and

2. Complete the MDH provider application to be an Organized Health Care Delivery System provider.

3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

B. Based on the service, equipment or supplies, vendors, the Organized Health Care Delivery System may procure items and services from a:

1. Commercial business

2. Community organization

3. Licensed professional

4. Day-to-Day Administrative Supports must:

a. Be at least 18 years old;

b. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

c. Must live in the state of Maryland by owning or renting a place to live in Maryland and continuously occupying it; and

d. Submit forms and documentation as required by the Financial Management and Counseling Services provider.

Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management and Counseling Services provider, as described in Appendix E.

Frequency of Verification:

Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Nursing Support Services provides a registered nurse (RN), licensed in the State of Maryland or has an active compact license, to perform Nursing Consultation, Health Case Management and Delegation services based on the participant's assessed need.

B. At a minimum, the RN must perform an initial nursing assessment.

1. This initial nursing assessment must include:

a. Review of the participant's health needs, including:

i. Health care services and supports that the participant currently receives; and

ii. The participant's health records, including any physician orders;

b. Performance of a comprehensive nursing assessment;

c. Clinical review of the participant's HRST, in accordance with Department policy; and

d. Completion of the Medication Administration Screening Tool, in accordance with Department policy.

2. The purpose of this initial nursing assessment is to determine the participant's assessed needs, particularly whether:

a. The participant's health needs require administration of medication;

b. The participant's health needs are delegable in accordance with the MBON's regulations; and

c. The participant's health needs are exempt from delegation in accordance with the MBON's regulations.

C. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Nursing Consultation services, then the Registered Nurse providing Nurse Consultation services must:

1. Provide recommendations to the participant on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources;

2. Develop or review health care protocols, including emergency protocols, with the participant and the participant's uncompensated caregivers; and

3. Develop or review communication process the participant may need to communicate effectively with:

a. The participant's health care providers, direct support staff, and uncompensated caregivers who work to ensure the health of the participant; and

b. Resources in the community that may be needed to support the participant's health needs, such as notifying the electrical company if the participant has medical equipment that requires prompt restoration of power in the event of a power outage.

D. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive, Health Case Management services, then the RN providing Health Case Management services must:

1. Provide recommendations to the provider and direct support staff on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources;

2. Develop a Nursing Care Plan and skills protocols regarding the participant's specific health needs; and

3. Provide training to the provider's direct support staff on how to address the participant's specific health needs, in accordance with the health care plans and skills protocols developed.

E. Health Case Management services, as provided in Section D above, does not include delegation of medications and medical/health/nursing treatments to the direct support staff and, therefore, does not require continuous nursing assessments of the participant or monitoring of the provision of services by the direct support staff.

F. Based on the initial nursing assessment, if the participant requires, and meets criteria to receive Delegation services then the RN providing Delegation services must:

1. Provide recommendations to the participant, the direct support staff, and, if applicable, the participant's providers on how to have the participant's health needs met in the community, including accessing health services available in the community and other community resources;

2. Develop a Nursing Care Plan and skills protocols regarding the participant's specific health needs in accordance with applicable regulations and standards of nursing care;

3. Provide training to direct support staff on how to address the participant's specific health needs and to perform the delegated nursing tasks, in accordance with the Nursing Care Plan and skills protocols developed;

4. Monitor, evaluate, and supervise the direct support staff's performance of delegated nursing tasks, including reviewing applicable documentation that must be maintained in accordance with applicable regulations and standards of nursing care;

5. Continually monitor and evaluate the participant's health by conducting nursing assessments and reviewing health data

documented and reported by direct support staff, in accordance with applicable regulations and standards of nursing care;

6. As per Code of Maryland Regulations 10.27.11, the delegating nurse shall be readily available when delegating a nursing task to an unlicensed individual, certified nursing assistant, or medication technician, and to address the participant's health needs as may arise emergently; and

7. Collaborate with the participant enrolled in the Self-Directed Services Delivery Model or the provider to develop policies and procedures governing delegation of nursing tasks in accordance with COMAR 10.27.11 and other applicable regulations.

G. Nursing Support Services (i.e., Nurse Consultation, Health Case Management and Delegation services) do not include provision of any direct nursing care services by a nurse to a participant.

SERVICE REQUIREMENTS:

A. The DDA will authorize the amount, duration, and types of services under this Medicaid waiver program service based on the participant's assessed level of service need and in accordance with other applicable requirements. If the participant's health needs change, the participant may submit a new request for additional hours or different services, with applicable supporting documentation, to the DDA.

B. Based on the initial nursing assessment, the participant may be eligible for Nursing Support Services if the participant meets the criteria below.

1. A participant is eligible to receive Nurse Consultation services if:

a. The participant is enrolled in the Self-Directed Services Delivery Model;

b. The participant receives a Medicaid waiver program service for which the participant has employer authority, as provided in Appendix E;

c. The participant directly employs, or contracts with, direct support staff under that employer authority and, therefore, is responsible for directing and managing direct support staff in provision of that Medicaid waiver program service; and

d. The participant's health needs are exempt from nurse delegation in accordance with applicable Maryland regulations.

2. A participant is eligible to receive Health Case Management services if:

a. The participant's health needs require performance of health tasks;

b. There are no medications or medical treatments or the administration of medication provided by paid staff or the participant is able to self medicate as determined by the RN CM/DN in accordance with the DDA self medication screening criteria;

c. Completion of medical treatments are completed by gratuitous care giver;

d. The participant either:

i. Is enrolled in the Provider Managed Traditional Services Delivery Model; or

ii. Is enrolled in the Self-Directed Services Delivery Model and receives a Medicaid waiver program service for which the participant does not have employer authority, as provided in Appendix E;

e. A provider, and not the participant, directly employs, or contracts with, direct support staff under the provider's employer authority and, therefore is responsible for directing and managing direct support staff in provision of that Medicaid waiver program service; and

f. The participant's health needs are exempt from delegation of medication and treatment administration in accordance with applicable Maryland regulations.

3. A participant is eligible to receive Delegation services if:

a. The participant's health needs require performance of nursing tasks, including administration of medication or medical/nursing treatments;

b. The participant is enrolled in either service delivery model;

c. Direct support staff provide the participant with a Medicaid waiver program service, whether employed by, or contracted with, a provider or the participant;

d. During provision of that Medicaid waiver program service, the direct support staff needs to perform delegated nursing tasks for the participant to maintain the participant's health and safety;

e. The nursing tasks are delegatable to the direct support staff in accordance with applicable DDA guidance and Maryland regulations; and

f. The participant's health needs are not exempt from delegation of nursing tasks in accordance with applicable Maryland regulations.

4. A participant is not eligible to receive any of these additional nursing services beyond the initial assessment (i.e., Nurse Consultation, Health Case Management or Delegation services) if:

a. The participant's health needs do not require performance of any health monitoring, completion of health related tasks or activities by paid caregivers;

b. The nursing tasks are not delegatable in accordance with applicable Maryland regulations; or

c. The participant does not have any direct support staff paid to provide any Medicaid waiver program service either under the Provider Managed Services Delivery Model.

C. The RN must complete and maintain documentation of delivery of these Medicaid waiver program services, including any nursing assessments, nursing care plans, health care plans and protocols, training of participant, direct support staff, and/or uncompensated caregivers, and any other documentation of services, in accordance with applicable Maryland laws and regulations, Department policies, and standards of nursing care.

D. The RN must comply with all applicable laws, regulations, and Department policies governing delivery of these Medicaid waiver program services, including but not limited to MBON's regulations, and the standards of nursing care. If there is a conflict between this Medicaid waiver program service and applicable MBON regulations, the applicable MBON regulations will control.

E. 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 or any other federal or State government funding program, must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SERVICE DEFINITION CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS

F. A participant cannot qualify, or receive funding from the Medicaid waiver program, for this Medicaid waiver program service if the participant:

1. Requires provision of direct nursing care services provided by a licensed nurse; or

2. 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.

G. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

H. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT 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 and skilled nursing services and behavior supports. Supports provided by this Waiver service are to improve and maintain the ability of the child to remain in and engage in community activities.

I. A legally responsible person, legal guardian, or relative (that is not a spouse) cannot be paid by the Medicaid waiver program, either directly or indirectly, to provide this Medicaid waiver program service.

J. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

****
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Nurse Consultation services – Assessment and document revisions and recommendations of the participant's health needs, protocols, and environment are limited to no more than 4-hours once every 3-months.

2. Nurse Health Case Management services are limited to no more than 4-hours once every 3-months.

3. Nurse Delegation – The frequency of assessment is minimally every 45 days, but may be more frequent based on the Maryland Board of Nursing 10.27.11 regulation and the prudent nursing judgment of the delegating Registered Nurse in meeting conditions for delegation. This is a person-centered assessment and evaluation by the Registered Nurse that determines duration and frequency of each assessment.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Services Provider
Individual	RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Support Services

Provider Category:

Agency

Provider Type:

Nursing Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity or if operating as a foreign corporation be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality nursing services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. Be in good standing with the IRS and SDAT;

F. Have Workers' Compensation Insurance;

G. Have Commercial General Liability Insurance;

H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. Satisfactorily complete required orientation and training;

K. Comply with the DDA standards related to provider qualifications; and

L. Complete and sign any agreements required by MDH or DDA.

2. Have a signed Medicaid Provider Agreement.

3. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or that spend any time alone with a participant must meet the following minimum standards:

1. Possess valid Maryland and/or Compact RN License;

2. Successful completion of the DDA RN CM/DN Orientation training.

3. Once completed DDA's training, maintain active status on DDA's registry of DD RN CM/DNs.

4. Be active on the DDA registry of DDA's RN CM/DNs;

5. Satisfactorily complete the online HRST Rater and Reviewer training;

6. Attend mandatory DDA trainings;

7. Attend all DDA provided nurse meetings;

8. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

11. Satisfactorily complete required orientation and training designated by the DDA; and

12. Complete necessary pre/in-service training based on the PCP.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of providers.

2. Nursing Service Agency for verification of staff member's licenses, certifications, and training.

3. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Nursing Services Provider – Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services – Initially and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Support Services

Provider Category:

Individual

Provider Type:

RN

Provider Qualifications

License *(specify):*

RN must possess valid Maryland and/or Compact RN License

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be certified based on compliance with meeting the following standards:

1. Possess a valid Maryland and/or Compact RN License;

2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation training;

3. Once completed DDA's training, maintain active status on DDA's registry of DDA RN CM/DNs;

4. Be active on the DDA registry of DDA RN CM/DNs;

5. Satisfactorily complete the online HRST Rater and Reviewer training;

6. Attend mandatory DDA trainings;

7. Attend all mandatory DDA provided nurse meetings;

8. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;

11. Have Commercial General Liability Insurance;

12. Satisfactorily complete required orientation and training designated by the DDA;

13. Complete necessary pre/in-service training based on the PCP;

14. Have 3 professional references which attest to the ability of the Registered Nurse to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

15. Demonstrate financial integrity through IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

16. Complete and sign any agreements required by the MDH or DDA;

17. Have a signed DDA Provider Agreement to Conditions for Participation; and

18. Have a signed Medicaid Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified RN.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services – Initially and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant Education, Training, and Advocacy Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. Covered expenses include:

1. Registration fees associated with training programs, conferences, and workshops;

2. Books and other educational materials; and

3. Transportation that enables the participant to attend and participate in training courses, conferences, and other similar events. Transportation services may not compromise the entirety of this Medicaid waiver program service.

C. The following expenses are not covered:

1. Tuition;

2. Airfare; or

3. Costs of meals or lodging, as per federal requirements.

SERVICE REQUIREMENTS:

A. Participant Education, Training, and Advocacy Supports may include education and training for participants directly related to building or acquiring skills.

B. Support needs for education and training are identified in the participant's file.

C. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts, and reasons that these services do not meet the participant's needs must be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

D. Participant Education, Training, and Advocacy Supports are not available at the same time as the direct provision of Transportation services.

E. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

F. A legally responsible individual, legal guardian, or a relative of a participant may not be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

G. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. Participant Education, Training, and Advocacy Supports is limited to 10 hours of training per participant per plan year.

2. The amount of training or registration fees for costs at specific training events, workshops, seminars, or conferences is limited to $500 per participant per plan year.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Participant Education, Training, and Advocacy Supports Agency
Agency	OHCDS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Education, Training, and Advocacy Supports

Provider Category:

Agency

Provider Type:

Participant Education, Training, and Advocacy Supports Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity with providing quality participant education, training or advocacy services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D.

F. Be in good standing with the IRS and SDAT;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Satisfactorily complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Complete and sign any agreements required by the MDH or DDA.

1. Have a signed Medicaid Provider Agreement;

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and

3. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH - for approval of Participant Education, Training and Advocacy Supports Agency.

2. Provider for verification of staff standards.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Education, Training, and Advocacy Supports

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least one Medicaid waiver service; and

2. Complete the MDH provider application to be an Organized Health Care Delivery System provider.

3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the Organized Health Care Delivery System.

2. Organized Health Care Delivery System provider for verification of staff qualifications.

Frequency of Verification:

1. MDH - Initially and at least every 3 years.

2. Organized Health Care Delivery System – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. The purpose of Remote Support Services is to support the participant to exercise greater independence over their lives. It is integrated into the participant's overall support system and reduces the amount of staff support a person uses in their home while ensuring health and welfare.

C. Remote Support Service includes:

1. Installation, repair, and maintenance of an electronic support system to remotely monitor the participant in the participant's primary residence;

2. Provision of training and technical assistance in accessing, using, and operating the electronic support system for the participant and individuals supporting the participant; and

3. Provision of staff to: (i) monitor the participant via the electronic support system; and (ii) stand-by and intervene by notifying emergency personnel, including, but not limited to, police, fire, and participant's direct support staff.

SERVICE REQUIREMENTS:

A. Before a participant may request this service, the participant's team must conduct a preliminarily assessment for appropriateness in ensuring the health and welfare of all individuals in the residence. The preliminary assessment includes consideration of the participant's goals, level of support needs, behavioral challenges, health risk, benefits, risk, and other residents in the home. The preliminary assessment must be documented in the participant's file.

B. Remote Support Services do not supplant supports for community integration and membership as identified in the PCP.

C. Remote Support Services are only available for individuals aged 18 or older and must be authorized by the DDA.

D. Each individual residing in the residence, their legal guardians, and teams must:

1. Be made aware of both the benefits and risks of the Remote Support Service;

2. Be advised of 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; and

3. Informed consent must be obtained for all individuals in the residence.

E. 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

F. Remote Support Services must be provided in real-time, by awake and alert staff at a monitoring base, who observe and provide prompts to the participant via an electronic support system that includes one or more of the following features:

1. Live two-way communication with the participant being monitored;

2. Motion sensing systems;

3. Radio frequency identification;

4. Web-based monitoring systems; and

5. Other devices approved by the DDA.

G. Systems may include live feeds, sensors (such as infrared, motion, doors, windows, stove, water, and pressure pads); cameras; help pendants; call buttons; and remote monitoring equipment.

H. Cameras and sensors are typically located in common areas. Other areas on the home will be considered based on assessed need; privacy and right considerations; and informed consent. For example, a person living alone in their own home may choose to use a Remote Support Services method in other areas of their home to support their PCP outcomes.

I. Use of the system may be restricted to certain hours as indicated in the participant's file.

J. To be reimbursed for operating an electronic support system, a provider must meet the following requirements:

1. The system to be installed must be preauthorized by the DDA.

2. Upon delivery to the participant (including installation) or maintenance performed, the electronic support system must be in good operating condition and repair in accordance with applicable specifications.

3. The provider must develop, maintain, and enforce written policies, approved by the DDA, which address:

a. How the provider, and electronic support system used, will maintain the participant's privacy;

b. How the provider will ensure the electronic support system used meets applicable information security standards; and

c. How the provider will ensure its provision of Remote Support Services complies with applicable laws governing participants' right to privacy.

4. The electronic support system and on-site response system must be designed and implemented to ensure the health and welfare of the participant(s) and achieve this outcome in a cost neutral manner as compared to the cost of direct support services.

K. Time limited direct supports from the existing services are available during transition to remote monitoring.

L. Remote Support Services are not available to participants receiving support services in Community Living-Enhanced Supports or Shared Living services.

M. Remote Support Services should be implemented in a cost neutral manner.

N. Remote Support Services does not include electronic audio-visual conferencing software applications reliant on the participant to maintain the connection.

O. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider
Agency	Remote Support Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Support Services

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least one Medicaid waiver service; and

2. Complete the DDA provider application to be an OHCDS provider.

3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

OHCDS providers shall:

1. Verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

2. Obtain Workers' Compensation if required by law.

Remote Support Services providers must:

1. Assure that the system will be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in their file; and

2. Have documentation that all vehicles used in the provision of services have automobile insurance.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or that spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Assure that the stand-by intervention (float) staff meet required credentials, license, certification, and training;

3. Complete necessary pre/in-service training based on the PCP;

4. Complete required orientation and training designated by the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the OHCDS.

2. OHCDS provider for verification of Remote Support System requirements and qualifications.

3. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. Initially and at least every 3 years.

2. Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Support Services

Provider Category:

Agency

Provider Type:

Remote Support Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality remote supports services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services and supports by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide remote monitoring services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. Be in good standing with the IRS and SDAT;

F. Have Workers' Compensation Insurance;

G. Have Commercial General Liability Insurance;

H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. Satisfactorily complete required orientation and training;

K. Comply with the DDA standards related to provider qualifications; and

L. Complete and sign any agreements required by the MDH or DDA.

2. Assure that the system will be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in their file;

3. Have a signed Medicaid Provider Agreement;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Assure that the stand-by intervention (float) staff meet required credentials, license, certification, and training;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Satisfactorily complete necessary pre/in-service training based on the PCP;

5. Satisfactorily complete required orientation and training designated by the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified provider.

2. Remote Support Service Provider for verification of staff qualifications.

3. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years thereafter.

2. Remote Support Services Provider – Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Services – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Shared Living emphasizes the long-term sharing of lives, forming of caring households, and close personal relationships between a participant and the host home. Shared Living facilitates the inclusion of the participant into the daily life and community of the supporter through the sharing of a home and creation of natural opportunities for participation in community life through social connectedness. It is an arrangement in which an individual, couple, or a family in the community share their home and life experiences with a person with a disability. The approach is based on a mutual relationship where both parties agree to share their lives.

B. Host home supports assure that the participant is safe and free from harm and has the support that they need to take risks and to work and participate in community activities. The primary responsibility of a Host Home is to make a real home where the individual, family or couple providing the home and the participant has a mutually satisfying and meaningful relationship.

C. The host home arrangement may be with:

1. An individual;
2. A couple; or
3. A family.

D. Shared Living services includes provision of the following supports in the host home arrangement:

1. Assistance, support, and guidance to the participant for the participant’s development, acquisition, and maintenance of skills necessary for the participant to live more independently, and to participant meaningfully in the community, as identified in the participant’s file; and

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation within this Medicaid waiver program service;

b. Delegated nursing tasks, based on the participant’s assessed need;

c. Personal care assistance, based on the participant's assessed need; and

d. Nursing Support Services.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older.

B. Shared Living services are direct (face-to-face) and indirect, DDA-licensed, or DDA-certified community-based provider managed services that are limited to homes in which one or two participants are supported.

C. Through the provision of this service, participants will acquire, maintain, or improve skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. To the extent that Shared Living is provided in community settings outside of the residence, the settings must be inclusive rather than segregated. Shared Living services may be provided up to 24 hours a day based on the needs of the participant receiving services.

D. The type and amount of assistance, support, and guidance are informed by the assessed level of need for physical, psychological, and emotional assistance established through the assessment and person-centered planning processes. The type and amount of assistance are delivered to enhance the autonomy of the participant, in line with their personal preferences and to achieve their desired outcomes.

E. Beginning July 1, 2020, the following levels will be used:

1. "Level 1" – will be used to support participants that do not require continuous supervision and monitoring. These participants may require prompts to complete activities of daily living and/or assistance with medical appointments and medication. They tend to not have challenging behaviors or a Behavior Support Plan in place. They participate in meaningful day services or have a job. They are able to recognize and avoid dangerous situations; and can independently evacuate premises in case of fire, emergencies, etc.

2. "Level 2" – will be used to support participants that require an increased level of supervision and monitoring. These participants require moderate assistance for mobility support or getting around in a wheelchair and assistance with frequent medical appointments and medications. They may require moderate assistance to complete activities of daily living and may display challenging behaviors requiring a Behavior Support Plan. They may participate in meaningful day services or have a job. They are not able to recognize and avoid dangerous situations and cannot independently evacuate premises in case of fire, emergencies, etc. therefore, requires prompting to evacuate.

3. "Level 3" – will be used to support participants that require ongoing supervision and monitoring to mitigate behavioral risk or provide health and safety supports. These participants may require maximum assistance for mobility support and getting around in a wheelchair or need adaptive equipment for ambulation. They may require maximum assistance for frequent medical appointments, medications, and specialist or health intervention for health and safety. They may have a HRST score of 5 with a Q indicator that is not related to behavior support. They may require maximum assistance to complete activities of daily living and may display severe challenging behaviors that require a Behavior Support Plan. They may participate in meaningful day services or have a job with additional supports or dedicated supports (i.e., 1:1, 2:1). They are usually not able to recognize and avoid dangerous situations and may need maximum assistance to evacuate premises in case of fire, emergencies, etc. therefore, requires prompting to evacuate. This is neither an exhaustive list of reasons a participant would require a Level 3 nor do all conditions need to be present concurrently.

F. The following supports may be provided to meet each participant's habilitative outcomes as documented in the file:

1. Assistance, support, and guidance (e.g., prompting, instruction, modeling, reinforcement) that enables the participant to:

a. Carry out activities of daily living, such as personal grooming and hygiene, dressing, making meals, and maintaining a clean environment;

b. Learn and develop practices that promote good health and wellness, such as nutritious meal planning, regular exercise, carrying through prescribed therapies and exercises, and awareness and avoidance of risk including, but not limited to, environmental risks, exploitation, or abuse, responding to emergencies in the home and community such as fire or injury, and knowing how and when to seek assistance.

c. Manage, or participate in the management of, their medical care including scheduling and attending medical appointments, filling prescriptions and self-administration of medications, and keeping health logs and records;

d. Manage their emotional wellness, including self-management of emotional stressors and states, such as disappointment, frustration, anxiety, anger, depression, post-traumatic stress disorder, and accessing mental health services. The service may include the implementation of the Behavior Support Plan which may involve collecting and recording the data necessary to evaluate progress and the need for revisions to the plan;

e. Fully participate, and when preferred, direct the person-centered planning process including identifying who should attend and what the desired outcomes are;

f. Manage their home, including arranging for utility services, paying bills, home maintenance, and home safety;

g. Achieve financial stability through managing personal resources, general banking and balancing accounts, record keeping, and managing financial accounts and programs such as ABLE accounts;

h. Communicate with providers, caregivers, family members, friends, and others face-to-face and using the telephone, correspondence, the internet, and social media which may require knowledge and use of sign language or interpretation for a participant whose primary language is not English;

i. Enable their own mobility by assisting them to use a range of transportation options including, but not limited to, buses, trains, cab services, driving, and carpools;

j. Develop and manage relationships as appropriate, share responsibilities for shared routines (such as preparing meals, eating together, carrying out routine home maintenance (such as light cleaning), planning and scheduling shared recreational activities, and other typical household routines), and resolve differences and negotiate solutions;

k. Develop and maintain relationships with members of the broader community (e.g., neighbors, coworkers, friends, and family) and manage problematic relationships;

l. Exercise rights as a citizen and fulfill their civic responsibilities and develop confidence and skills to enhance their contributions to the community, such as:

i. Voting and serving on juries;
ii. Attending public community meetings;

iii. Participating in community projects and events with volunteer associations and groups; and

iv. Serving on public and private boards, advisory groups, and commissions;

m. Encourage the development of the participant’s personal interests, such as hobbies, appreciation of music, and other experiences the participant enjoys or may wish to discover;

n. Participate in the participant’s preferred activities of community life, such as shopping and going to restaurants, museums, movies, concerts, dances, and faith-based services; and

o. Engage in decision-making, including but not limited to providing guidance in identifying and evaluating options and choices against the participant’s set of personal preferences and desired outcomes and identifying supports for decision-making within the community.

2. Identification of risk to the participant and the implementation of actions, including, but not limited to, reporting incidents as required by the DDA and State regulations; and

3. Provide transportation to activities related to health, community involvement and others, as noted in the file.

G. The Shared Living arrangement is chosen by the participant, with input from their person-centered planning team, and with the Shared Living host and Shared Living Provider in accordance with the participant’s needs. The primary life sharing host caregiver may receive additional assistance and relief based on the needs of the participant.

H. Compensation to host home includes additional staff assistance, relief, host home related transportation costs, and

Nursing Support Services associated with the provision of service.

I. Effective July 1, 2018, the following criteria will be used for participants to access Shared Living:

1. The participant does not have family or relative supports; and

2. The participant chooses this living option.

J. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The provider must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's file; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

3. Transportation services may not compromise the entirety of this Medicaid waiver program service.

K. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

L. The Medicaid payment for Shared Living host home services may not include either of the following items from the participant:

1. Room and board; or

2. Any assessed amount of contribution by the participant for the cost of care.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SERVICE DEFINITION CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS

M. 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 CFR § 441.301(c)(4), as amended.

N. Shared Living services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Day Habilitation, Employment Services, Live-in Caregiver Supports, Medical Day Care, Personal Supports, Respite Care Services, Supported Living, or Transportation services.

O. Shared Living services are not available to participants receiving support services in other residential models including Community Living-Group Homes, Community Living-Enhanced Supports, and Supported Living service.

P. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by the DDA's Regional Office and additional standalone Nursing Support Services hours can be authorized.

Q. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives except siblings.

R. The individual, couple, or family who provides the host home and services and supports to the participant shall:

1. Be chosen by the participant and reflect their preferences and desires;

2. Be compensated for sharing a home and their lives with the participant; and

3. Be established as an independent contractor.

S. Shared Living can be provided in a variety of community settings and activities that promote opportunities for increased independence and inclusion. Through the person-centered planning process, all opportunities should be explored based on the person's preferences and support their desired outcomes and goals. The setting should not have institutional qualities. Considering the participant's overall Person-Centered Plan, activities should not isolate or segregate. If the participant chooses any disability specific classes, activities, events or programs, the choice must be documented in the file.

T. Except for siblings, 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 unless otherwise approved by the DDA and in accordance with the applicable requirements set forth in Section C-2.

U. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

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Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Shared Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Shared Living

Provider Category:

Agency

Provider Type:

Shared Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

2. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

3. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability residential services;

4. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

5. Demonstrate the capability to provide or arrange for the provision of all services by submitting, at a minimum, the following documents with the application:

a. A program service plan that details the agency's service delivery model;

b. A business plan that clearly demonstrates the ability of the agency to provide Shared Living services;

c. A written quality assurance plan to be approved by the DDA;

d. A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

e. Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

11. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;

12. Be in good standing with the IRS and SDAT;

13. Have Workers' Compensation Insurance;

14. Have Commercial General Liability Insurance;

15. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

16. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

17. Satisfactorily complete required orientation and training;

18. Comply with the DDA standards related to provider qualifications; and

19. Complete and sign any agreements required by the MDH or DDA.

20. Be a certified OHCDS;

21. Have a signed Medicaid Provider Agreement;

22. Have documentation that all vehicles used in the provision of services have automobile insurance; and

23. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Individual, couple, or family who provides the host home and services and supports to the participant shall:

1. Be at least 18 years old;

2. Possess current First Aid and CPR training and certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

4. Satisfactorily complete required orientation and training designated by the DDA;

5. Satisfactorily complete necessary pre/in-service training based on the PCP;

6. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services;

7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services; and

8. Have a service agreement articulating expectations.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of provider.

2. Shared Living Provider for verification and completion of couple’s or family’s training, background check, and service agreement.

3. Financial Management and Counseling Service (FMCS) provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years thereafter.

2. Shared Living Provider – Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Service provider - prior to services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Support Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Support Broker Services assist the participant:

1. Making informed decisions in arranging for, directing, and managing services the individual receives, including decisions related to personnel requirements and resources needed to meet the requirements;

2. Accessing and managing identified supports and services;

3. Performing other tasks as assigned by the participant and as authorized by regulations adopted or guidance issued by the federal Center for Medicare and Medicaid Services (CMS) under 1915 (c) of Social Security Act.

B. Support Broker Services provides information and assistance in support of self-direction. Support Broker Services is used to:

1. Provide information to ensure that participants understand the responsibilities involved with directing their services; and

2. Assist the participant in developing the skills necessary to independently direct and manage their Medicaid waiver program services and providers (including employees, vendors, and DDA Providers) as the employer of record.

C. Through this service, information may be provided to the participant about:

1. Person-centered planning and how it is applied;

2. The range and scope of individual choices and options;

3. The process for changing the Person-Centered Plan and the individual self-directed budget;

4. The grievance process;

5. Risks and responsibilities of self-direction;

6. Free of choice of provider and employees;

7. Individual rights; and

8. The reassessment and review of support schedules.

D. Assistance may be provided to the participant with:

1. Defining goals, needs and preferences, identifying and accessing services, supports and resources;

2. Practical skills training to enable participants to independently direct and manage waiver services. Examples of skills training include: providing information on recruiting and hiring direct support professionals, managing workers, terminating workers, and providing information on effective communication, problem-solving, and conflict resolution.

3. Development of risk management agreements;

4. Development of an emergency backup plan;

5. Recognizing and reporting critical events;

6. Independent advocacy, to assist in filing grievances and complaints when necessary; and

7. Developing strategies for training all of the participant's employees on PORII and ensuring that all critical incidents are reported to the Office of Health Care Quality and DDA.

SERVICE REQUIREMENTS:

A. The extent of the assistance furnished to the participant is specified in the service implementation plan or job description.

B. This service does not duplicate other Medicaid waiver services, including case management. Support Broker Services may not duplicate, replace, or supplant case management (Coordination of Community Service).

C. Additional Support Broker Services up to 30 hours per month, as needed by the participant and within the participant's total approved annual budget, may be purchased with unallocated funds due to:

a. The scope, frequency, and intensity of supports needed (for example 24/7 supports, multiple staff and services);

b. Language barriers; and

c. The lack of support network to assist with the self-direction requirements.

D. Service hours must be necessary, documented, and evaluated by the team.

E. Support Brokers shall not make any decision for the participant, sign off on any timesheets or invoices, or hire or fire workers. Support Brokers may provide support for reviewing timesheets and invoices but the participant always makes the decision.

F. Support Broker Services are required:

1. When a relative, legally responsible person, representative payee, and legal guardian serve as paid staff.

2. When the participant selects a relative, legal guardian, or legally responsible person as their designated representative.

3. When the participant employs any person to provide Day-to-Day Administrative Supports.

G. Support Brokers must:

1. Sign and adhere to a code of conduct;

2. Satisfactorily complete all DDA required Support Broker trainings and requirements; and

3. Provide assurances that they will implement the Person-Centered Plan as approved by DDA or their designee in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

H. Individuals and organizations providing Support Broker Services may provide no other paid service to the DDA-operated Medicaid waiver participant.

I. Support Broker administrative non-billable activities include:

1. Attending training;

2. Correspondence or research;

3. Creating and issuing invoices; and

4. Travel.

J. Support Broker Services are an optional service to support participants enrolled in the SDS Delivery Model that do not use a relative, legally responsible individual, representative payee, and guardian serve as paid staff, as further described in Appendix E. A participant enrolled in the Traditional Services Delivery Model is not eligible to receive this service.

K. A relative (who is not a spouse), legally responsible person, legal guardian, or Social Security Administration representative payee of the participant may be paid to provide this Medicaid waiver program service in accordance with applicable requirements set forth in Appendix C-2.

1. A spouse or legally responsible person may provide Support Broker services, but may not be paid by this Medicaid waiver program.

2. A relative who is paid to provide Support Broker services cannot:

a. Provide this Medicaid waiver program service for more than 40 hours a week;

b. Serve as the participant's designated representative, managing the participant's as provided in Appendix E; or

c. Provide any other Medicaid waiver program services which are funded by the Medicaid waiver program under this Appendix C.

L. Scope and duration of Support Broker Services may vary depending on the participant's choice and need for support, assistance, or existing natural supports. The scope and duration must be within the service description, requirements, and limitations.

M. If any employee is a relative, legally responsible person, representative payee, or legal guardian; then no relative, legally responsible person, representative payee, or legal guardian may serve as Support Broker.

N. A designated representative may never be a Support Broker for that participant.

O. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Person-Centered Plan authorization for:

1. Initial orientation and assistance up to 15 hours prior to waiver enrollment which is billed as a Medicaid State Plan service.

2. Support Broker Services up to 4 hours per month.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Support Broker Professional
Agency	Support Broker Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:

Individual

Provider Type:

Support Broker Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual employees must meet the following standards:

1. Be at least 18 years old;

2. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

3. Be certified by the DDA to demonstrate core competency related to self-determination, Department of Labor requirements, consumer directed services and service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies.

4. Satisfactorily complete all required orientation and training designated by DDA including the Policy on Reportable Incidents and Investigations and Support Broker trainings; and

5. Agree and adhere to the Support Broker Code of Conduct.

Individuals must submit forms and documentation as required by the Financial Management and Counseling Services agency. Financial Management and Counseling Services must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Financial Management and Counseling Services provider, as described in Appendix E.

Frequency of Verification:

Financial Management and Counseling Services provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:

Agency

Provider Type:

Support Broker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality information and assistance for self-directed services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agency's service business model;

(2) A business plan that clearly demonstrates the ability of the agency to provide services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(1) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

2. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D.

3. Be in good standing with the Internal Revenue Service and State Department of Assessments and Taxation (SDAT);

4. Have Workers' Compensation Insurance;

5. Have Commercial General Liability Insurance;

6. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

7. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

8. Satisfactorily complete required orientation and training;

9. Comply with the DDA standards related to provider qualifications; and

10. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA.

11. Have documentation that all vehicles used in the provision of services have automobile insurance; and

12. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

3. Be certified by the DDA to demonstrate core competency related to self-determination, Department of Labor requirements, consumer directed services and service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies.

4. Satisfactorily complete all required orientation and training designated by DDA including the Policy on Reportable Incidents and Investigations and Support Broker trainings; and

5. Agree and adhere to the Support Broker Code of Conduct.

Individuals must submit forms and documentation as required by the Financial Management and Counseling Services agency. Financial Management and Counseling Services must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. Financial Management and Counseling Services provider, as described in Appendix E.

2. Support Broker Agency for verification of individual staff members' certifications and training.

Frequency of Verification:

1. FMCS provider – Prior to service delivery.

2. Support Broker Agency – Prior to service delivery.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Supported Living services provide participants with a variety of individualized services to support living independently in the community.

B. Supported Living services are individualized to the participant's needs and interests as documented in the participant's PCP and must be delivered in a personalized manner.

C. Supported Living services assists the participant to: (a) learn informed decision making and problem-solving related to performing activities of daily living and instrumental activities of daily living required for the participant to live independently; and (b) engage in community-based activities of the participant's choosing within the participant's personal resources.

D. Supported Living services enable the participant to: (a) live in a home of their choice located where they want to live; and (b) live with other participants or individuals of their choosing;

E. This service includes Nursing Support Services. The scope of the Nursing Support Services is defined under the stand-alone service in Appendix C.

F. Supported Living services are provided in the participant's own house or apartment.

G. This Medicaid waiver program service includes provision of:

1. Direct support services for provision of coordination, training, supports, and/or supervision (as indicated in the PCP) as provided in Section A above;

2. The following services provided in combination with, and incidental to, the provision of this Medicaid waiver program service:

a. Transportation to and from and within this Medicaid waiver program service;

b. Delegated nursing tasks, based on the participant's assessed need; and

c. Personal care assistance, based on the participant's assessed need.

SERVICE REQUIREMENTS:

A. The participant must be 18 years of age or older.

B. 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.

C. The level of staffing and meaningful activities provided to the participant under this Medicaid waiver program service must be based on the participant's assessed level of service need.

1. Based on the participant's assessed needs, the DDA may authorize dedicated hours for 1:1 and 2:1 staff-to-participant supports.

2. The following criteria will be used to authorize 1:1 and 2:1 staff-to-participant ratio:

a. The participant has an approved Behavior Support Plan documenting the need for 1:1 or 2:1 staff-to-participant ratio necessary 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 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 specific, documented behavioral need for up to 6 months while a Behavior Support Plan gets authorized and developed.

d. 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.

3. Dedicated hours can be used to support more than one participant if it meets their assessed needs and the following requirements are met:

a. The participants are retired, transitioning from one meaningful day service to another, recovering from a health condition, or receiving less than 40 hours of meaningful day services;

b. Support is documented in each participant's PCP and provider service implementation plan; and

c. Dedicated hours are billed for only one participant.

D. Under Supported Living service, the following requirements and restrictions relating to the residence applies:

1. If participants choose to live with housemates, no more than 4 individuals (including other participants receiving services) may share a residence; each housemate, including the participant, is hereinafter referred to as a "resident" or collectively as "residents".

2. If the participant shared their home with another individual (who may be a participant as well) who is their spouse, domestic partner, their child, siblings, or significant other, they may share a bedroom if they choose;

3. Except as provided in D.2 above, each resident of the setting shall have a private bedroom;

4. Services may include up to 24 hours of shared support per day, as specified in the PCP;

5. The residence must be a private dwelling and is not a licensed individual site of a provider. The residence must be owned or leased by at least 1 of the individuals residing in the home or by a participant's authorized representative, such as a family member or legal guardian;

6. The residents are legally responsible for the residence in accordance with applicable federal, State, and local law and regulation and any applicable lease, mortgage, or other property agreements; and

7. All residents must have a legally enforceable lease that offers them the same tenancy rights that they would have in any public housing option.

E. The following criteria will be used for participants to access Supported Living:

1. Participant chooses to live independently or with roommates; and

2. This residential model is the most cost-effective service to meet the participant's needs.

F. If transportation is provided as part of this Medicaid waiver program service, then:

1. The participant cannot receive Transportation services separately at the same time as provision of this Medicaid waiver program service;

2. The provider must:

a. Provide, or arrange for provision of, transportation to meet the needs of the participant identified in the participant's PCP; and

b. Use the most cost-effective mode of transportation, with priority given to the use of public transportation; and

c. Transportation services may not compromise the entirety of this Medicaid waiver program service.

G. If direct support staff perform delegated nursing tasks as part of this Medicaid waiver program service, then:

1. The participant must receive Nursing Support Services under this Medicaid waiver program; and

2. The delegated nursing tasks:

a. Must be provided by direct support staff who are certified as a Medication Technician by the MBON; and

b. May not compromise the entirety of this Medicaid waiver program service.

H. If personal care assistance services are provided as part of this Medicaid waiver program service, then the personal care assistance may not comprise the entirety of the service. For purposes of this Medicaid waiver program service, personal care assistance means the provision of supports to assist a participant in performing activities of daily living and instrumental activities of daily living.

I. In the event that additional Nursing Support Services Delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by the DDA's Regional Office and additional standalone Nursing Support Services and Delegation support service hours can be authorized.

J. Supported Living services are not available to participants receiving supports in other residential support services models including Community Living Group Home, Shared Living, and Community Living Enhanced Supports.

K. A relative (who is not a spouse), legally responsible person, or legal guardian who does not live in the residence may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2. A legally responsible person, legal guardian, or relative who lives in the residence with the participant cannot be paid, either directly or indirectly, to provide this Medicaid waiver program service.

L. Supported Living 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, Day Habilitation, Employment Services, Live-in Caregiver Supports, Medical Day Care, Personal Supports, Respite Care Services or Shared Living services.

M. 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.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding

for the service under the Medicaid waiver program.

N. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

O. Supported Living can be provided in a variety of community settings and activities that promote opportunities for increased independence and inclusion. Through the person-centered planning process, all opportunities should be explored based on the person's preferences and support his or her desired outcomes and goals. The setting should not have institutional qualities. Considering the person's overall PCP, activities should not isolate or segregate.

P. Direct Support Professional services may be provided in an acute care hospital for the purposes of supporting the participant's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services.

2. These necessary Waiver services:

a. Must be identified in the individual's PCP;

b. Must be provided to meet the individual's needs and are not otherwise covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, or under another applicable requirement; and

d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserve the participant's functional abilities.

Q. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1 Complete the MDH provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland business entity, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of 5 years demonstrated experience and capacity providing quality developmental disability residential services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the agencies' service delivery model;

(2) A business plan that clearly demonstrates the ability of the agency to provide Supported Living services;

(3) A written quality assurance plan to be approved by the DDA;

(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and

(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. Be in good standing with the IRS and SDAT;

F. Have Workers' Compensation Insurance;

G. Have Commercial General Liability Insurance;

H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. Satisfactorily complete required orientation and training;

K. Comply with the DDA standards related to provider qualifications; and

L. Complete and sign any agreements required by the MDH or DDA.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval. The renewal license is good for up to a 3 year period.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have required credentials, license, certification, and training to provide services;

3. Possess current First Aid and CPR certification or Emergency Medical Technician (EMT);

a. The First Aid and CPR training must include a hands-on, in-person component.

b. 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.

c. Written materials may be used online and at the employee's own pace.;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Satisfactorily complete necessary pre/in-service training based on the PCP;

6. Satisfactorily complete required orientation and training designated by the DDA;

7. Possess a valid driver’s license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the provider.

2. Provider for verification of staff qualifications, certifications, and training requirements.

3. Financial Management and Counseling Service (FMCS) provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Provider - Prior to service delivery and continuing thereafter.

3. Financial Management and Counseling Service provider - prior to services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. For purposes of this service definition, “allowable expenses”, are defined as actual costs associated with moving and establishing a new household. Examples may include:

1. Cost of a security deposit that is required to obtain a lease on an apartment or house;

2. Reasonable cost, as defined by the DDA, of essential household goods, such as furniture, window coverings, and kitchen, bed, and bath items which cannot be transferred from the previous location to the new one;

3. Fees or deposits associated with set-up of, initial access to, or installation of essential utilities, and for telephone, electricity, heating, and water;

4. Cost of services necessary for the participant’s health and safety, such as pest removal services and one-time cleaning prior to moving in; and

5. Moving expenses.

C. Transition Services may include the cost for training direct support professionals prior to the transition date who will be supporting participants with complex medical or behavioral needs to ensure health and welfare on the first day of community services.

D. Transition Services do not include payment for the costs of the following items:

1. Monthly rental or mortgage expense;

2. Food;

3. Regular utility charges;

4. Monthly telephone fees; and

5. Entertainment related household items or services such as televisions, video game consoles, DVD players, cell phones, or monthly cable fees.

E. Transition Services will not include payment for room and board.

SERVICE REQUIREMENTS:

A. The participant must be unable to pay for, and is unable to obtain assistance from other sources or services to pay for, expenses associated with moving and establishing a new household, as documented in the participant's file.

B. From the allowable Transition Services, the participant or their designated representative will prioritize and select items to be purchased based on the participant's preferences, up to the maximum amount of funding approved by the DDA.

C. The participant will own all of the items purchased under this service. The items shall transfer with the participant to their new residence and any subsequent residence. If the participant no longer wants any item purchased under this service, the item shall be returned to the DDA unless otherwise directed.

D. The DDA must receive, review, and approve the list of items and budget for transition expenses before this service is provided.

E. Transition Services are furnished only to the extent that they are reasonable, necessary, and based on the participant's needs.

F. Transition Services may be provided to an individual leaving an institution up to 180 days prior to moving out which is billed as a Medicaid administrative service.

G. When furnished to participants returning to the community from a Medicaid institutional setting, the costs of these services are considered to be an administrative cost.

H. The DDA may approve payment for Transition Services incurred no more than 180 days in advance of participant's enrollment in this waiver.

I. Any goods funded by this Medicaid waiver program service must be in good operating condition and repair in accordance with applicable specifications. Any services funded by this Medicaid waiver program must be performed in accordance with standard workmanship and applicable specifications.

J. This service cannot pay for purchase of items and goods from the participant's relative, legal guardian, or legally responsible person as defined in C-2-e.

K. Transition Services does not include items or services otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources.

L. 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, MSDE, DORS, DHS, or any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant's file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

M. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

N. 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. The maximum payment for this service may not exceed $5,000 per participant during their lifetime.

2. Transition items and goods must be procured within 60 days after moving.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least 1 Medicaid waiver service; and

2. Complete the MDH provider application to be an OHCDS provider.

OHCDS providers shall verify the qualifications, licenses, credentials, and experience of all individuals and entities they contract or employ and have a copy of the same available upon request.

Vendors who provide the items, goods, or services that are allowable expenses under this service. Examples include:

1. Apartment or house landlords;

2. Vendors selling household items;

3. Utility services providers;

4. Pest removal or cleaning service providers; and

5. Moving service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the OHCDS.

2. OHCDS for verification of items.

Frequency of Verification:

1. MDH - Initially and at least every 3 years.

2. OHCDS – Prior to service delivery.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. 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.

B. For purposes of this Medicaid waiver program service, the participant’s community is defined as: places the participant lives, works, shops, or regularly spends their days. The participant’s community does not include vacations in the State. It does not include other travel inside or outside of the State of Maryland unless it is a day trip.

C. Transportation services can include:

1. Orientation services in using other senses or supports for safe movement from one place to another;

2. Accessing Mobility and volunteer Transportation services such as transportation coordination and accessing resources;

3. Travel training such as supporting the participant and their family in learning how to access and use informal, generic, and public transportation for independence and community integration;

4. Transportation services provided by different modalities, including: public and community transportation, taxi services, and ride sharing services;

5. Mileage reimbursement and an agreement for transportation provided by another individual using their own car; and

6. Purchase of prepaid transportation vouchers and cards, such as the Charm Card and Taxi Cards.

SERVICE REQUIREMENTS:

A. Services are available to the participants living in their own home or in the participant's family home.

B. The Program will not make payment to spouses or legally responsible individuals for furnishing Transportation services.

C. A relative (who is not a spouse) of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2. A legally responsible person, legal guardian, or spouse cannot be paid by the Medicaid waiver program, either directly or indirectly, to provide this Medicaid waiver program service unless otherwise approved by the DDA due to extraordinary circumstances in accordance with the applicable requirements set forth in Section C-2.

D. Payment rates for services must be customary and reasonable as established or authorized by the DDA.

E. Transportation services shall be provided by the most cost-efficient mode available that meets the needs of the participant and shall be wheelchair accessible when needed.

F. Transportation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Home, Day Habilitation, Employment Services (with exception for follow along supports as authorized by the DDA), Medical Day Care, Personal Supports, or Respite Care.

G. 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.

1. These efforts must be documented in the participant’s file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

H. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

I. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation is limited to $7,500 per year per participant.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Transportation Professional or Vendor
Agency	OHCDS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Transportation Professional or Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Have required credentials, license, or certification as noted below as noted below;

3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a for non-commercial drivers;

4. Possess a valid driver's license for non-commercial drivers;

5. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of service, for non-commercial providers;

6. Satisfactorily complete required orientation and training designated by the DDA;

7. Satisfactorily complete necessary pre/in-service training based on the PCP for non-commercial drivers;

8. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

9. Demonstrate financial integrity through the IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

10. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA; and

11. Have a signed Medicaid Provider Agreement.

Orientation, Mobility and Travel Training Specialists must attend and have a current certification as a travel trainer from one of the following entities:

1. Easter Seals Project Action (ESPA);

2. American Public Transit Association (APTA);

3. Community Transportation Association of America (CTAA);

4. National Transit Institute (NTI);

5. American Council for the Blind (ACB);

6. National Federation of the Blind;

7. Association of Travel Instruction (ATI);

8. Be a DORS approved vendor/contractor; or

9. Other recognized entities based on approval from the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Transportation Professional and Vendors.

2. Financial Management and Counseling Services providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH - Initially and at least every 3 years.

2. Financial Management and Counseling Services providers – Prior to delivery of services and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the MDH to provide at least one Medicaid waiver service; and

2. Complete the DDA provider application to be an OHCDS provider.

OHCDS providers shall:

1. Verify the licenses and credentials of individuals providing services with whom they contract or employ and have a copy of the same available upon request.

2. Obtain Workers' Compensation if required by law.

The OHCDS and Financial Management and Counseling Services provider must ensure the individual or entity performing the service meets the qualifications noted below as applicable to the service being provided:

1. For individuals providing direct transportation, the following minimum standards are required:

A. Be at least 18 years old;

B. For non-commercial providers, possess a valid driver's license for vehicle necessary to provide services; and

C. For non-commercial providers, have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

D. For commercial providers like Uber and Lyft, do not need to provide proof of automobile insurance.

2. Orientation, Mobility and Travel Training Specialists – must attend and have a current certification as a travel trainer from one of the following entities:

A. Easter Seals Project Action;

B. American Public Transit Association;

C. Community Transportation Association of America;

D. National Transit Institute;

E. American Council for the Blind;

F. National Federation of the Blind;

G. Association of Travel Instruction;

H. Division of Rehabilitation Services approved vendors/contractor; or

I. Other recognized entities based on approval from the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the OHCDS.

2. OHCDS provider and FMCS provider for verification of staff qualifications.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. OHCDS and FMCS provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Vehicle Modifications are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle Modifications are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration by removing barriers to transportation.

B. Vehicle Modifications may include:

1. Assessment services to (a) help determine specific needs of the participant as a driver or passenger, (b) review modification options, and (c) develop a prescription for required modifications of a vehicle;

2. Assistance with modifications to be purchased and installed in a vehicle 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;

3. Non-warranty vehicle modification repairs; and

4. Training on use of the modification.

C. Vehicle Modifications do not include the purchase of new or used vehicles, general vehicle maintenance or repair, State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

SERVICE REQUIREMENTS:

A. A vehicle modification assessment and/or a driving assessment will be required when not conducted within the last year by a DORS approved vendor.

B. A prescription for Vehicle Modifications must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist. The prescription for Vehicle Modifications applies only to the year/make/model of the vehicle specified on the Vehicle Equipment and Adaptation Prescription Agreement (VEAPA).

C. The vehicle owner is responsible for:

1. The maintenance and upkeep of the vehicle; and

2. Obtaining and maintaining insurance that covers the Vehicle Modifications.

D. The program will not correct or replace Vehicle Modifications provided under the program that have been damaged or destroyed in an accident.

E. Vehicle Modifications are only authorized to vehicles meeting safety standards once modified.

F. Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition and repair in accordance with applicable specifications.

G. The Program cannot 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.

H. Vehicle modification funds cannot be used to purchase vehicles for participants, their families, or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

I. Vehicle Modifications may not be provided in day or employment services provider owned vehicles.

J. 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, MSDE, DORS, DHS, and any other federal or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be documented in the participant’s file.

2. If these services are deemed by the participant's person-centered planning team to be inappropriate to meet the specific needs of the participant, the exploration efforts and reasons that these services do not meet the participant's needs shall be documented in the participant's file.

3. The DDA has authority to determine if further efforts must be made, and documented, prior to authorization of funding for the service under the Medicaid waiver program.

K. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of receiving community based services and avoiding institutionalization.

L. 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.

M. Anyone paid to provide a Medicaid waiver service, including participant's employees, are considered a Medicaid Provider, subject to all laws and regulations associated with a Medicaid Provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	OHCDS Provider
Individual	Vehicle Modification Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

OHCDS Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved by the DDA to provide at least one Medicaid waiver service; and

2. Complete the MDH provider application to be an OHCDS provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

The OHCDS must ensure the individual or entity performing the service meets the qualifications including:

1. Be a DORS approved vendor or DDA certified vendor;

2. The VEAPA must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist; and

3. The adaptive driving assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement as to whether it meets the individual's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of certified Vehicle Modification Vendor.

2. Financial Management and Counseling Services provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. Financial Management and Counseling Services - Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Vehicle Modification Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the MDH provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;

2. Be a DORS approved Vehicle Modification service vendor;

3. Satisfactorily complete required orientation and training designated by the DDA;

4. For driving assessments, satisfactorily complete person specific pre/in-service training to be aware of the participant's communication preferences, sensitivities, and health or behavior strategies so they can adapt training as needed.

5. Have 3 professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's policy in Annotated Code of Maryland, Health General, Title 7;

6. Demonstrate financial integrity through the IRS, Maryland Department of Health, and Medicaid Exclusion List checks;

7. Complete and sign any agreements required by the Maryland Department of Health (MDH) or DDA; and

8. Have a signed Medicaid Provider Agreement.

The Adapted Driving Assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and providing a statement as to whether it meets the individual's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. MDH for approval of the OHCDS.

2. OHCDS providers for verification of entities and individuals they contract or employ.

Frequency of Verification:

1. MDH – Initially and at least every 3 years.

2. OHCDS providers – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participants as per COMAR 10.09.48 as an administrative service.

Training includes:

a. Home and community based service expectations related to integration and full access to the greater community;

b. Coordinating with other service delivery systems; and

c. Assessing service settings and Community Setting Questionnaire completion.

d. Person-Centered Planning development, including:

a. Person-Centered Thinking;

b. Person-Centered Planning cycle, timeline, roles and responsibilities;

c. Assessing needs and mitigating risk; and

d. Ability to work collaboratively with service providers, families, and community members.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Day Habilitation
Personal Supports
Behavioral Support Services
Community Development Services
Employment Services
Housing Support Services
Remote Support Services

1. Will any in-person visits be required?

- ◉ **Yes.**
- ○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

- ☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Virtual supports is an electronic method of service delivery. Virtual support must ensure the participant's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Virtual support must be provided in accordance with federal and State requirements, policies, guidance, and regulations, including Health Insurance Portability and Accountability Act (HIPPA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH), and their applicable regulations to protect the privacy and security of the participant's protected health information.

The Medicaid provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address virtual supports including privacy.

The Coordinator of Community Services are responsible for monitoring the implementation of the Person-Centered Plan on an ongoing basis. Within each quarter of the Person-Centered Plan Annual Plan Date, at a minimum, the Coordinator of Community Service must monitor service delivery in person at the place of service as specified in the approved Person-Centered Plan. The Coordinator of Community Service should visit the person in the setting of the service; and, for each quarterly visit, a different service setting. The Coordinator of Community Services also monitors that the services and supports meet the participant's privacy, health and safety needs, and that the participants remain satisfied with their services and supports including virtual supports as identified in their approved Person-Centered Plan.

☒ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

The purpose of virtual supports is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote the participant's ability to live independently, and meaningfully participate in their community. Virtual supports are geared towards intentional learning (e.g., career planning, taking skill building classes) and can also be used towards helping a person do something more independently like remote job coaching.

Virtual supports must support a participant to reach identified outcomes in their Person Centered Plan. Virtual supports may supplement in-person direct supports. Medicaid waiver program services may not be provided entirely via virtual supports.

The use of virtual supports must be agreed to by the participant as outlined in the participant's file and provider service implementation plan. Participants must have an informed choice between in-person and virtual supports. Virtual supports cannot be the only service delivery provision for the participant seeking the given service.

Virtual supports cannot be used for the Medicaid provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the Person-Centered Plan.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

The provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address:

1. Identifying whether the participant's needs, including health and safety, can be addressed safely while they are using virtual supports;

2. 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 person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency; and

3. How a participant will get emergency interventions if the person experiences an emergency, including contacting 911 if necessary.

4. Providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22. Provider Program Service Plans must include details on how they will identify 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 person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency by July 1, 2026, if not already included.

The Coordinator of Community Services monitors the services and supports to assess if they meet the participant's privacy, health and safety needs, hands on assistance/physical assistance (as applicable), and that the participants remain satisfied with their services and supports, including virtual supports, as identified in their approved Person-Centered Plan.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

The provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address:

1. 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 person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency; and

2. Providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22. Providers Program Service Plans must include details on how they will identify 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 person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency by July 1, 2026 if not already included.

The Medicaid provider is responsible for providing assistance with the use of technology. The Medicaid provider is also responsible for the cost 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.

Coordinators of Community Services will assess and monitor the quality and effectiveness of virtual supports during the quarterly monitoring assessment and more frequently as noted in the Person-Centered Plan. If additional supports are needed they can be explored through person-centered planning. If there is a desire by the participant to change the way services are delivered, a revised Person-Centered Plan and provider service implementation plan will be required.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Participants and their teams shall assess the quality and effectiveness of virtual supports to meet the participant's assessed needs and preferences in accordance with applicable Medicaid waiver program requirements, set forth in the Medicaid waiver application.

Virtual supports, including use of phones, cannot be used to assess a participant for a medical emergency. The DDA Provider must develop and maintain written policies to address processes for preventing and responding to a medical emergency during use of virtual supports, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies.

At a minimum, such policies must address:

1. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual supports;

2. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home) and ensuring they are present during provision of virtual supports in case the participant needs hands on assistance/physical assistance, support with using technology, or experiences an emergency during provision of virtual supports; and

3. Processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.

4. The virtual supports must comply with all federal and State requirements, policies, guidance, and regulations.

Coordinators of Community Services will assess and monitor the quality and effectiveness of virtual supports during the quarterly monitoring assessment and more frequently as noted in the Person-Centered Plan. If there is a desire by the participant to change the way services are delivered, a revised Person-Centered Plan and provider service implementation plan will be required.

Coordinator of Community Services monitoring includes reviewing incident reports and identifying risks with the participant's health and safety. Health and safety concerns shall be reported to the DDA Regional Office Quality Enhancement staff. DDA Regional Office Quality Enhancement staff will review incidents and conduct investigations as per the Policy on Reportable Incidents and Investigations.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

This section describes the minimum background check and investigation requirements for providers under applicable law.

A participant self-directing and providers may opt to perform additional checks and investigations as it sees fit.

Criminal Background Checks

Current Regulations

The DDA's regulation requires providers to have criminal background checks prior to service delivery. DDA's regulations also require that each DDA-licensed and DDA-certified community-based providers complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System; or (2) a National criminal background check via a private agency, with whom the provider contracts. If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years."

The same requirements are required for participants self-directing services as indicated within each service qualification.

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. If this background check identifies a criminal history that "indicate[s] behavior potentially harmful" to participants receiving services, then the provider is prohibited from employing or contracting with the individual. See Code of Maryland Regulations (COMAR) 10.22.02.11, Maryland Annotated Code Health-General Article § 19-1901 et seq., and Code of Maryland Regulations Title 12, Subtitle 15. Code of Maryland Regulations 10.22.02.11B also provides the DDA discretion to prevent individuals from providing services.

Background screening is required for volunteers who:

(1) Are recruited as part of an agency's formal volunteer program; and
(2)Spend time alone with participants.

Criminal background checks are not required for people who interact with or assist participants as a friend or natural support, by providing assistance with shopping, transportation, recreation, home maintenance and beautification etc.

These requirements are also applied for all employees and staff of a participant self-directing services.

Child Protective Services Background Clearance

The State also maintains a Centralized Confidential Database that contains information about child abuse and neglect investigations conducted by the Maryland State Local Departments of Social Services. Individual providers and staff engaging in direct one-to-one interactions with children under the age of 18 must have a Child Protective Services Background Clearance.

State Oversight of Compliance with These Requirements

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.

Annually the Quality Improvement Organization will review Financial Management and Counseling Services providers' records for required background checks of staff working for participants enrolled in the Self-Directed Services Delivery Model, described in Appendix E.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

◉ **No. The state does not conduct abuse registry screening.**

○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual 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 by a legally responsible individual is in the best interest of the participant; (d) the state processes to 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; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

(a) THE TYPES OF LEGALLY RESPONSIBLE INDIVIDUALS WHO MAY BE PAID TO FURNISH SUCH SERVICES AND THE SERVICES THEY MAY PROVIDE

DEFINITIONS:

Extraordinary Care

Extraordinary care means care exceeding the range of activities that a legally responsible person would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to assure the health and welfare of the participant and avoid institutionalization.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

Spouse

For purposes of this Waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Relative

For purposes of this Waiver, a relative is defined as a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew.

Legal Guardian

For purposes of this Waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code’s Family Law or Estates & Trusts Articles.

The State makes payment to a legally responsible person, who is appropriately qualified, for providing extraordinary care for the following services:

1. Personal Supports

2. Respite

A legally responsible person may not be paid to provide these Waiver program services if it does not constitute extraordinary care as defined above.

A service provided by a legally responsible person is subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

METHOD FOR DETERMINING THAT THE AMOUNT OF PERSONAL CARE OR SIMILAR SERVICES PROVIDED BY A LEGALLY RESPONSIBLE INDIVIDUAL 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

Participants enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Provider Managed Service Delivery Model may use their legally responsible person to provide services in the following circumstances, as documented in the participant’s file:

1. The participant is either a child or an adult with needs that meet extraordinary care beyond scope of what the

legally responsible person would ordinarily perform for individuals of the same age who did not have a disability or chronic illness;

2. The legally responsible person is the choice of the participant, or the authorized representative of a minor, which is supported by the team;

3. There is a lack of qualified providers to meet the participants needs;

4. When a relative or spouse is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant; and

5. The legally responsible person provides no more than 40-hours per week of the service. This includes when the legally responsible person is an employee for one service and a vendor for another service.

A Substitute Judgement document is 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.

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legally responsible person, legal guardians and relatives are not allowed to provide direct care services.

THE STATE POLICIES TO DETERMINE THAT THE PROVISION OF SERVICES BY A LEGALLY RESPONSIBLE INDIVIDUAL IS IN THE BEST INTEREST OF THE PARTICIPANT

To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan by the Coordinator of Community Services:

1. Choice of the legally responsible person to provide Waiver services truly reflects the participant's or the authorized representative of a minor's wishes and desires;

2. The provision of services by the legally responsible person is in the best interests of the participant and their family;

3. The provision of extraordinary care services by the legally responsible person is necessary based on the participant's needs identified in their Person-Centered Plan;

4. The services provided by the legally responsible person will increase the participant's independence and community integration;

5. There are documented steps in the Person-Centered Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis, should the legally responsible person acting in the capacity of employee no longer be available;

6. A written agreement that identifies people, beyond family members, who will support the participant in making their own decision, is completed; and

7. The legally responsible person must sign a service agreement to provide assurances to the DDA that they will actively support hiring of employees or providers to expand the circle of support and implement the Person-Centered Plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.

In addition, Support Broker Services are required under the Self-Directed Services Delivery Model, when a relative, legally responsible individual, representative payee, and guardian serve as paid staff in order to assure proper oversight and quality assurance as well as reduce conflicts of interest.

Effective April 1, 2026, participants seeking to use a legally responsible person to provide services must submit a request form. The request has to be approved before the legally responsible person can begin providing services.

A Substitute Judgement document is 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.

(d) THE STATE PROCESSES TO 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

Effective April 1, 2026, participants seeking to use a legally responsible person to provide services must submit a request form. The request has to be approved before the legally responsible person can begin providing services.

A Substitute Judgement document is 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.

(e) ANY LIMITATIONS ON THE CIRCUMSTANCES UNDER WHICH PAYMENT WILL BE AUTHORIZED OR THE AMOUNT OF PERSONAL CARE OR SIMILAR SERVICES FOR WHICH PAYMENT MAY BE MADE

The legally responsible person can provide no more than 40-hours per week of the service. This includes when the legally responsible person is an employee for one service and a vendor for another service.

(f) ADDITIONAL SAFEGUARDS THE STATE IMPLEMENTS WHEN LEGALLY RESPONSIBLE INDIVIDUALS PROVIDE PERSONAL CARE OR SIMILAR SERVICES

Coordinators of Community Services conduct quarterly monitoring and follow-up activities which includes accessing services delivery and participant’s satisfaction and health and welfare.

(e) THE PROCEDURES THAT ARE USED TO IMPLEMENT REQUIRED STATE OVERSIGHT, SUCH AS ENSURING THAT PAYMENTS ARE MADE ONLY FOR SERVICES RENDERED

Annually, the DDA or its designees will conduct a randomly selected, statistically valid sample of services provided by legally responsible persons to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

(a) THE TYPES OF RELATIVES/LEGAL GUARDIANS WHO MAY BE PAID TO FURNISH SUCH SERVICES AND THE SERVICES THEY MAY PROVIDE

DEFINITIONS

Relative

For purposes of this Waiver, a relative is defined as a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew.

Legal Guardian

For purposes of this Waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

Spouse

For purposes of this Waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Provider Managed Services Delivery Model may use a legal guardian or relative (who is not a spouse), who is appropriately qualified, to provide:

1. Community Development Services;
2. Employment Services;
3. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support (relatives can provide this service if they are not also a legal guardian or legally responsible person);
4. Nursing Support Services;
5. Personal Supports;
6. Respite Care Services;
7. Shared Living (siblings only);
8. Support Broker;
9. Supported Living;
10. Transportation; and
11. Live-in Caregiver Supports (siblings only).

A service provided by a legal guardian or relative is subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

(b) CIRCUMSTANCES WHEN PAYMENT MAY BE MADE, METHOD FOR DETERMINING THAT THE AMOUNT OF SERVICES PROVIDED BY A RELATIVE/LEGAL GUARDIAN

An unpaid legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's Person-Centered Plan:

1. The participant is either a child or an adult with needs that meet extraordinary care beyond scope of what the legal guardian or relative, would ordinarily perform for individuals of the same age who did not have a disability or

chronic illness;

2. The legal guardian or relative is the choice of the participant, which is supported by the team;

3. There is a lack of qualified provider to meet the participant's needs;

4. When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant; and

5. The unpaid legal guardian or relative provides no more than 40-hours per week of the service. This includes when the legally responsible person is an employee for one service and a vendor for another service.

Effective April 1, 2026, participants seeking to use a legal guardian or relative to provide services must submit a request form. The request has to be approved before the legal guardians or relatives can begin providing services.

A Substitute Judgement document is required for participants who have legal guardians and relatives providing services that have decision making authority over the selection of waiver service providers.

Legal guardians, paid to provide guardianship services, may not provide paid Medicaid waiver program services to the participant they provide guardianship services.

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide services noted above.

(c) THE STATE POLICIES TO DETERMINE THAT THE PROVISION OF SERVICES BY A LEGAL GUARDIAN OR RELATIVE IS IN THE BEST INTEREST OF THE PARTICIPANT

To ensure the use of a legal guardian or relative (who is not a spouse) to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan by the Coordinator of Community Services:

1. Choice of the legal guardian or relative as the provider truly reflects the participant's wishes and desires;

2. The provision of services by the legal guardian or relative is in the best interests of the participant and their family;

3. The provision of extraordinary care services by the legal guardian or relative is necessary based on the participant's needs identified in their Person-Centered Plan;

4. The services provided by the legal guardian or relative will increase the participant's independence and community integration;

5. There are documented steps in the Person-Centered Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis; should the legal guardian or relative acting in the capacity of employee no longer be available;

6. A written agreement that identifies people, beyond family members, who will support the participant in making their own decision, is completed; and

7. The legal guardian or relative must sign a service agreement to provide assurances to DDA that they will actively support hiring of employees or providers to expand the circle of support and implement the Person-Centered Plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.

In addition, Support Broker Services are required under the Self-Directed Services Delivery Model, when a relative,

legally responsible individual, representative payee, and guardian serve as paid staff in order to assure proper oversight and quality assurance as well as reduce conflicts of interest.

Effective April 1, 2026, participants seeking to use legal guardians and relatives to provide services must submit a request form. The request has to be approved before the legal guardians and relatives can begin providing services. A Substitute Judgement document is required for participants who have legal guardians and relatives providing services that have decision making authority over the selection of waiver service providers.

(d) THE STATE PROCESSES TO ENSURE THAT LEGAL GUARDIAN OR RELATIVES WHO HAVE DECISION-MAKING AUTHORITY OVER THE SELECTION OF WAIVER SERVICE PROVIDERS USE SUBSTITUTED JUDGEMENT ON BEHALF OF THE INDIVIDUAL

Effective April 1, 2026, participants who have legal guardians or relatives providing services must have a signed Substituted Judgement document.

(e) ANY LIMITATIONS ON THE CIRCUMSTANCES UNDER WHICH PAYMENT WILL BE AUTHORIZED OR THE AMOUNT SERVICES FOR WHICH PAYMENT MAY BE MADE

The legal guardians or relatives can provide no more than 40-hours per week. This includes when the legal guardian or relative is an employee for one service and a vendor for another service.

(f) ADDITIONAL SAFEGUARDS THE STATE IMPLEMENTS WHEN LEGAL GUARDIAN OR RELATIVES PROVIDE SERVICES

Coordinators of Community Services conduct quarterly monitoring and follow-up activities which includes accessing services delivery and participant's satisfaction and health and welfare.

(g) THE PROCEDURES THAT ARE USED TO IMPLEMENT REQUIRED STATE OVERSIGHT, SUCH AS ENSURING THAT PAYMENTS ARE MADE ONLY FOR SERVICES RENDERED

Annually, the DDA or its designees will conduct a randomly selected, statistically valid sample of services provided by legal guardians and relatives to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

The DDA is working with provider associations and currently enrolled Medicaid service providers to share information about new opportunities to deliver services to waiver participants.

The DDA website includes:

1. The MDH - Application and Approval Processes for DDA Qualified Supports/Services Providers. This document:

a) Describes specific requirements for completion and submission of initial application for prospective providers and renewal applications for current providers seeking DDA approval to render supports, services and/or goods under the DDA-operated Medicaid waiver program,

b) Provides definition and eligibility requirements for qualified service professionals regarding each support or service rendered, and

c) Delineates actions taken by the DDA following receipt of an applicant's information and provides timelines for review and approval or disapproval of an application.

Upon receipt of a new application, the applicable DDA regional office will review the application within 30 days and an approval or denial letter is sent.

2. Eligibility Requirements for Qualified Supports and Services Providers - A document that describes each support and/or service and the specific eligibility criteria required to render the support/service.

3. Instructions for Completing the Provider Application - Interested applicants may download or request a hard copy from the DDA Regional Office for the following:

a) DDA Application to Render Supports and Services in the DDA-operated Medicaid waiver program;

b) Provider Agreement to Conditions of Participation - A document that lists regulatory protection and health requirements, and other policy requirements that prospective providers must agree and comply with to be approved by the DDA as a qualified service provider in the supports waivers; and

4. Provider Checklist Form – A checklist form which applicants must use to ensure that they have included all required information in their applications;

Interested community agencies and other providers can submit the MDH application and required attachments at any time. For services that require a DDA license, applicants that meet requirements are then referred to the Office of Health Care Quality to obtain the license.

Support brokers may be sanctioned for violating DDA's waiver requirements, statutes, regulations, policies, guidance, instructions, or the support broker's agreements with the Maryland Department of Health or DDA. Sanctions include submitting a corrective action plan, withholding payment, recovery of an overpayment, suspension from providing services to participants, or de-certification from providing services to participants with a bar on re-applying to provide support broker services for any length of time. By way of example and not limitation, sanctions would be available for overutilization of authorized services, billing for two or more participants at the same time, and billing for support broker services provided by staff that DDA has not certified as support brokers. Support brokers will have an opportunity to appeal in accordance with COMAR 10.01.03.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

◉ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☒ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☒ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☒ **The HCBS must be identified in the individual's person-centered service plan; and**

☒ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

a) The following Medicaid waiver program services can be provided in the acute care hospital setting:

1. Community Development Services;

2. Day Habilitation Services;

3. Personal Support Services;

4. Community Living - Group Home Services;

5. Community Living - Enhanced Support Services;

6. Supported Living Services.

b) Direct Support Professional staffing services may be provided in an acute care hospital for the purposes of supporting the participant’s personal, behavioral, and communication supports not otherwise provided in that setting. These supports will assist the participant in communicating their needs and utilizing behavioral strategies to support healing, use of medical strategies to address the acute care health issues, and discharge to their community.

c) There are no differences in the rate billed for these services.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-PM 1 - Number and percentage of newly enrolled licensed/certified providers who meet standards prior to service provision. Numerator = number of newly enrolled licensed/certified providers who meet standards prior to service provision. Denominator = total number of newly enrolled licensed/certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Qualified Provider Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-PM 2 - Number and percentage of licensed/certified providers who continue to meet standards. Numerator = number of licensed/certified providers who continue to meet standards. Denominator= Total number of currently enrolled licensed/certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Qualified Provider Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

QIO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-PM 3 - Number and percentage of paid claims provided by qualified non-licensed/certified providers (including Organized Health Care Delivery System vendors, self-directed staff, and self-directed non-licensed providers). Numerator = number of paid claims provided by qualified non-licensed/certified providers Denominator = total number of paid claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-PM 5 - Number and percentage of paid claims whose services were provided by trained staff. Numerator = number of paid claims whose services were provided by trained staff. Denominator = total number of paid claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
QP- PM 4 - Number and percentage of paid, self-directed service claims, provided by qualified providers (includes employees, vendors, providers and OHCDS). Numerator = number of paid, self-directed service claims, provided by qualified providers. Denominator = total number of self-directed services paid claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Quality Improvement Organization	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Participants self-directing their services may request assistance from the Advocacy Specialist or the DDA Self-Direction lead staff. The DDA staff will document encounters.

The DDA’s Provider Services staff provides technical assistance and support on an on-going basis to licensed and certified providers and will address specific remediation issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. These remediation efforts will be documented in the provider’s file.

The Quality Improvement Organization in collaboration with the Council on Quality and Leadership conducts Personal Outcome Measure interviews with participants and Basic Assurance interviews with providers to collect and analyze information regarding individual and systemic deficiencies. The Quality Improvement Organization also conducts the National Core Indicators Survey in an effort to measure and improve the performance of DDA’s service system. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement. DDA considers recommendations and has made updates to improve policies, waiver proposals, including

improving performance measures based on this data.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**

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

The following quality improvement activities are designed to improve compliance with the Qualified Provider performance measures.

1. Measure: DDA Licensed Providers continue to meet required licensure and standards:

a. The 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.

b. The DDA's Provider Services staff will meet with providers 75-90 days prior to the renewal date to review a provider self-assessment tool, if needed, to assess current status, updates, challenges, and concerns related to their 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.

c. The DDA's Regional Offices will meet with the provider's Executive Director/Chief Executive Officer and Board President for all providers that have not submitted their application for renewals 60 days prior to the expiration date. The meeting will include the provider's proposed workplan with milestones and due dates. Meetings may also be scheduled to discuss other provider-specific concerns.

d. The DDA's Director of Provider Services will track, monitor, and report findings and trends to DDA management; and

e. The DDA will share the renewal application with the Office of Health Care Quality, upon receipt from the provider for a simultaneous dual review of all documents.

2. Measure: Licensed providers staff meet training requirements.

a. To ensure provider staff have the required training, the DDA Providers Services team or it’s designee will collect training attestations for each provider quarterly.

b. The Quality Improvement Organization will conduct a statistically random sample to confirm compliance.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

The Community Pathways Waiver services include various employment, meaningful day, support, and residential services. Waiver services are provided in the individual's own home or the community which is available for the public to use and visit and therefore presumed to meet the HCB Settings requirement. All providers and settings must comply with all the settings criteria in 42 CFR § 441.301. Effective January 1, 2018, to be enrolled as a provider of services authorized under §§1915(c) or 1915(i) of the Social Security Act, the provider shall comply with the provisions of this regulation and 42 CFR 441.301 and includes specific provider requirements.

The following services are provided at licensed sites which must comply with the home and community-based settings requirement prior to enrollment as a waiver service provider:

1. Community Living-Group Home at provider operated residential sites.
2. Community Living-Enhanced Supports are services provided at provider operated residential sites.
3. Day Habilitation services are provided at provider operated sites and in the community.
4. Career Exploration –services are provided at provider operated sites and in the community.
5. Medical Day Care services are provided at provider operated sites and in the community.
6. Respite Care Services can be provided in the participant's home, a community setting, a Youth Camp certified by Maryland Department of Health, or a site licensed by the Developmental Disabilities Administration. There are no residential services provided.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

All new providers must comply with the home and community-based settings requirement prior to enrollment as a new waiver service provider and ongoing. As part of the application process to become a Medicaid provider under the Waiver, the DDA will review and assess for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, the DDA will conduct site visits for site-based services to confirm compliance with the home and community-based settings requirements.

Each site is assessed for home and community-based settings compliance, utilizing the Community Settings Checklist prior to approval. Following initial approval, sites are assessed for compliance every 3-5 years and more frequently as needed. For sites that were approved prior to the compliance date of March 17, 2023, they are assessed for compliance every 3-5 years from the compliance date and more frequently as needed.

As per Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, any modification of the rights or conditions under §§D and E of this regulation shall be supported by a specific assessed need and justified in the person-centered services plan in accordance with 42 Code of Federal Regulations 441.301(c)(2)(xiii).

Ongoing assessment is part of the annual person-centered service planning and provider performance reviews. Coordinator of Community Services assesses participants' service settings for compliance with home and community-based settings requirements and completes a Community Setting Questionnaires (CSQ). Each Community Setting Questionnaires must demonstrate that the program provider meets the home and community-based setting requirements annually and each time a placement changes.

DDA reviews Community Setting Questionnaires flagged as potentially not meeting standards. DDA follows up with the Coordinator of Community Services and provider agency and remediate as applicable. DDA actions may include conducting an on site assessment and issuing corrective action as needed.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

○ **No, the waiver does not include provider-owned or controlled settings.**

◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the**

state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

☒ **Each individual has privacy in their sleeping or living unit:**

- ☒ **Units have entrance doors lockable by the individual.**
- ☒ **Only appropriate staff have keys to unit entrance doors.**
- ☒ **Individuals sharing units have a choice of roommates in that setting.**
- ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☒ **Individuals have the freedom and support to control their own schedules and activities.**

☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Plan (PCP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

The DDA approves and contracts with provider organizations, which provide appropriately qualified staff, known as Coordinators of Community Services (CCS), to provide case management services to participants through the Medicaid State Plan Targeted Case Management (TCM) for People with Developmental Disabilities authority.

Minimum Qualifications

Each CCS assigned to an applicant/participant must meet the following minimum qualifications specified in Medicaid's TCM regulations for people with developmental disabilities and DDA's regulations set forth in the Code of Maryland Regulations (COMAR) 10.09.48.05 and 10.22.09.06, respectively, as amended.

Under Medicaid's Targeted Case Management regulations, Coordinators of Community Service:

1. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;

2. Ensure that each individual receives a person-centered plan that is designed to meet the individual's needs and in the most cost effective manner; and

3. Annually advise participants of their right to choose among qualified providers of services to include Coordination of Community Services.

Ineligibility for Employment

An individual is ineligible for employment by a Coordination of Community Services provider organization or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed or certified provider organization and entity;

2. Is simultaneously providing services under a DDA-operated Medicaid waiver to a participant as the participant's employee or as the employee of a vendor or provider.

3. Is on the Maryland Medicaid exclusion list;

4. Is on the federal List of Excluded Individuals/Entities (LEIE);

5. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);

6. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;

7. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland, unlawfully interfering with the rights of an individual with a development disability; or

8. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to participants receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and COMAR 12.15.02

Necessary Skills for a CCS

In accordance with Medicaid's Targeted Case Management Code of Maryland Regulations 10.09.48.05, Coordinators of Community Services must demonstrate competency-based skills and working knowledge in the following areas:

1. Negotiation and conflict management;

2. Crisis management;

3. Community resources including generic programs, local programs, State programs, and federal programs and resources;

4. Determining the most integrated setting appropriate to meet the participant's needs;

5. Coordinating and facilitating planning meetings;

6. Assessing, planning, and coordinating services;

7. Monitoring the provision of services to participants;

8. Allied service delivery systems, including Medicaid, mental health, substance abuse, social services, juvenile justice, vocational rehabilitation, and corrections; and

9. Regulations governing services for participants with developmental disabilities.

Required Staff Training

All Coordination of Community Service providers shall ensure through appropriate documentation that each CCS, CCS Supervisor, and Quality Assurance staff member receives any training required by the DDA including Person-Centered Planning Development.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The CCS provides the participant and their legally authorized representative, (as applicable), with written and oral information about DDA services and the process of developing a PCP. The CCS assists the participant and their team by facilitating the team meeting and creating a PCP. This includes explaining assessments, timelines, and any other necessary steps. The information is shared in ways that are easy to understand, using written and spoken communication. If needed, the Coordinator of Community Services will use methods like sign language, assistive technology, or interpreter services to ensure the involvement of the participant.

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 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 self-directed orientation/training must be completed before enrollment. There is no cost to participants to attend.

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 CCS provides each participant, and their legally authorized representative, (as applicable) with information about the participant’s rights to determine their person-centered planning team. The participant and their legally authorized representative, (as applicable) are encouraged to invite family members, friends, DDA advocacy specialists, coworkers, professionals, and anyone else in their circle of support that they desire to be part of person-centered planning team meetings. The participant is encouraged to involve important people in their life in the planning process. However, the participant and their legally authorized representative, (as applicable) also retains the authority to exclude any individual from participating in the development of their PCP with the CCS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Development of the PCP

Who Develops?

The participant directs the development of their PCP.

The CCS is responsible for the development of the PCP with the participant and their legally authorized representative, (as applicable), and their chosen team. The participant and their legally authorized representative, (as applicable) is the primary contributor to the plan and may receive support from other persons selected by the participant in developing the plan. The CCS facilitates the planning process.

Participants can use a variety of person-centered planning methodologies such as the Charting the LifeCourse (i.e., Integrated Support Star, Life Trajectory, and Exploring Life Possibilities), Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy.

Who Participates?

The participant directs the development of their PCP.

As further specified in subsection d. above, the participant, and their legally authorized representative, (as applicable) are the central members of the team responsible for planning and developing a PCP Person-Centered Plan. The participant and their legally authorized representative, (as applicable) on the participant’s behalf, may invite others important to the participant to be part of the planning process, including the participant’s staff and providers. However, the participant and their legally authorized representative, (as applicable) retains the authority to exclude any individual not required to participate in the development of their Person-Centered Plan with the Coordinator of Community Services. The participant and their legally authorized representative, (as applicable), indicates their agreement with the Person-Centered Plan by signing a Signature page that can be in writing or electronically as per DDA policy.

Participants may also seek support with decision making from other individuals. Supported decision making means a process by which an adult, with or without having entered a supported decision–making agreement, utilizes support from a series of relationships in order to make, communicate, or put into action the adult’s own life decisions.

Timing of Plan

The initial plan is developed as part of the Medicaid waiver program application process and updated within 365 days of the annual plan date, or more frequently when there are changes to the participant’s circumstances or services.

The CCS contacts the participant and their legally authorized representative, (as applicable), to obtain the participant's preferences for the best time and location of the planning meeting. Meetings may be held at the participant's home, job, a community site, day program, virtually, or wherever they feel most comfortable reviewing and discussing their plan.

(b) Types of Assessments Conducted to Support Development of the PCP

In addition to obtaining a variety of information and assessments about the participant’s needs, preferences, life outcomes, and health from other sources as specified below, the CCS uses the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS)®.

The HRST 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.

The SIS measures the participant's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports the participant requires.

In addition to these assessments, the CCS gathers information regarding the participant's needs, outcomes, and preferences from the participant, their family, friends, and any other individuals invited to participate in the planning process. The CCS also reviews other formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., Speech Pathologist, Occupational Therapist, Physical Therapist), as appropriate.

(c) Provision of Information Regarding Available Waiver Program Services to the Participant

During initial meetings, quarterly monitoring activities, and the annual PCP development meeting, the CCS shares information with the participant and their legally authorized representative, (as applicable), about available Medicaid waiver program services, as well as local county resources and services, community resources, generic resources, natural supports, and services available through other programs, Medicaid State Plan services, and qualified providers (e.g., individuals, community-based service agencies, vendors, and entities). The CCS also provides information on how to access a comprehensive list of DDA services and DDA providers. The CCS Coordinator of Community Services assists the participant in integrating the delivery of support needed.

(d) How Development Process Ensures Plan Addresses the Participant’s Goals, Needs, and Preferences

The DDA requires each CCS provider to use a participant-directed, person-centered planning approach. This approach identifies the participant’s strengths, assets, and those things that are both important to and important for, as well as, needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for a PCP. As part of this person-centered planning approach, the CCS gathers information from the participant, and their legally authorized representative, (as applicable), their circle of support (family and friends), assessments, and observations.

Based on a person-centered planning approach, a PCP is developed. The PCP identifies supports and services to meet the participant’s needs, outcomes, and preferences so they may live in their home or community and whether those supports and services will be provided by natural or informal supports, other local, State, and federal programs, or this Medicaid waiver program. Skills to be developed or maintained under Medicaid waiver program services are determined based on the individualized goals and outcomes as documented in their PCP. The PCP will also address any need for training for the participant, and their legally authorized representative, (as applicable), family member(s), and provider or direct care staff in implementing the PCP.

(e) How Waiver and Other Services are Coordinated

The CCS assists the participant in coordinating local community services, generic resources, natural supports, services available through other programs, Medicaid State Plan services, and Medicaid waiver program services. The CCS provides case management services, including assisting the participant to connect with this array of services and supports and ensures their coordination.

The PCP is the focal point for coordinating services available under various programs, including this Waiver program. It reflects who the person is and the things that are important to and for them, and identifies their needs, goals, interests, and preferences for achieving their desired lifestyle. The Coordinator of Community Services assists the participant in exploring assistive technology to obtain an independent lifestyle. The PCP serves as a working plan that addresses the participant's specific needs, with a focus on the participant having control over their services and supports while working towards achieving and maintaining a good quality of life, well–being, and informed choice, in accordance with the participant’s goals related to social life, career, spirituality, citizenship, advocacy, and preferences. The PCP includes focus areas that participants can explore related to employment, communication, life-long learning, community involvement, day-to-day life, finance, home and housing, health and wellness, and relationships.

(f) How the Development Process Provides for the Assignment of Responsibilities to Implement and Monitor the Plan

In general, the PCP outlines roles and responsibilities for services and supports.

The Coordinator of Community Services is responsible for monitoring the implementation of the Person-Centered

Plan on an ongoing basis. Within each quarter of the Person-Centered Plan Annual Plan Date, at a minimum, the Coordinator of Community Service must monitor service delivery in person at the place of service as specified in the approved Person-Centered Plan. The Coordinator of Community Service should visit the person in the setting of the service; and, for each quarterly visit, a different service setting. The CCS also monitors that the services and supports meet the participant's health and safety needs and that the participants remain satisfied with their services and supports as identified in their approved Person-Centered Plan.

In addition, when a change in health status occurs or an incident is reported, the CCS facilitates the evaluation of the participant's service needs to address the change, if appropriate. The CCS also monitors that services are delivered in the manner described in the PCP, and that the participant's outcomes, needs, and preferences, as identified in the PCP, are being addressed and met during their quarterly reviews and on an annual basis.

(g) How or When the Plan is Updated

At least annually, or more frequently when there is a change in a participant's needs, health status, or circumstances, the participant and their legally authorized representative, (as applicable), and their self-selected person-centered planning team must come together to review and revise the PCP. This process must be facilitated by the CCS. These required updates to a participant's PCP ensure that it reflects the current needs, preferences, and outcomes of the participant.

The PCP is updated in accordance with the person-centered planning process identified in this subsection d.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk Assessment

During development of the PCP, the participant's planning team, facilitated by the CCS, 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 of the participant. In addition to objective assessments, the family can be a key source of information on risk assessment and mitigation, especially when supporting participants under the age of 21.

To promote optimum health, to mitigate or eliminate identified risks, and to avert health complications or deaths, the CCS must complete the electronic HRST for all participants annually as part of the PCP planning process. The HRST is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable, field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the participant. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once a participant is fully screened, the HRST produces Service and Training Considerations that can be used by staff and families. Service and Training Considerations describe what further evaluations, specialists, assessments, or clinical interventions may be needed to support the participant based on the identified health risks.

Participants with an HRST level score of 3 or higher are considered higher risk thus requiring increased monitoring and supervision by their health care professionals and service provider (as applicable). If a participant's HRST Health Care Level becomes a score of 3 or higher, a RN must complete a Clinical Review of the HRST as per the standard process with this national tool. (Note: The RN must complete training and be certified as a HRST Reviewer in order to maintain the validity and reliability of the tool.) The HRST contains a comments section where the CCS (the HRST Rater) can give reasons for why a score was selected. This will allow the certified Nurse "HRST Reviewer", to evaluate the appropriateness of the score. The Nurse (HRST Reviewer) performs record reviews and may perform interviews to validate each HRST rating and score computation. All clarifying information about a rating area entered by the Nurse (HRST Reviewer) is written in the "Comments" section for the appropriate item. The Nurse (HRST Reviewer) also reviews and can add comments as necessary, for the Evaluation/Service and Training Recommendations.

In addition to medical concerns, the participant, family, and other team members can identify other areas of risk using the 'Charting the LifeCourse' framework, such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports.

Risk Mitigation Strategies

After these risk assessments are completed and reviewed, potential risk mitigation strategies are discussed as part of the team meeting, are based on the unique needs of the participant, and their family, and must ensure health and safety while affording a participant the dignity of risk. The CCS assists the participant and their team in the development of these risk mitigation strategies including back-up plans and emergency plans, which are incorporated into the PCP and service record.

Once identified, the CCS will incorporate individualized risk mitigation strategies, including back–up plans and emergency plans into the PCP, in accordance with the participant's and their family's needs, goals, and preferences. Risk mitigation strategies may include: (1) participant, family, and staff training; (2) Assistive Technology; (3) back-up staffing plans; (4) emergency management strategies for various risks such as complex medical conditions, identified elopement risk, or previous victim of abuse, neglect, and exploitation; and (5) other strategies as identified through an approved Behavior Support Plan or Nursing Care Plan.

In addition, all participants and Medicaid service providers must have a system for providing emergency back-up services and supports as part of their service plan, policies, and procedures, which are reviewed by the DDA and OHCQ. Emergency back-up plans are reviewed by the CCS during quarterly monitoring to ensure strategies continue to meet the needs of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CCS 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 CCS assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, outcomes, and preferences.

The CCS informs the participant of available DDA-licensed and approved providers. The participant, and their legal guardian or authorized representative (if applicable), may explore, interview, and exercise choice regarding these potential providers. The CCS assists the participant in scheduling visits with providers and provides a list of providers from which they may make informed choices (including the DDA's website).

The CCS and the DDA encourages participants to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency. Potential providers can discuss how they can support the participant and their family in a way that meets the participant's needs, outcomes, and preferences related to achieving the participant's desired lifestyle.

For services and programs at a specific location, participants and their families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Office of Long Term Services and Supports (OLTSS) ensures compliant performance of this waiver by delegating specific responsibilities to the Operating State Agency, the DDA, through an Interagency Agreement.

All PCPs of participants entering the waiver are submitted to the DDA for review prior to service initiation. The DDA reviews the PCPs and supporting documentation to ensure compliance with all policy and regulations. Changes to services (amount, duration, scope) in a PCP (through the annual process or due to a change in a participant's needs) must be submitted to the DDA for review and approval.

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 interested in the self-directed service delivery model in order for the plan to be approved. 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.

There is no cost to participants to attend.

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.

PCPs are also reviewed during:

1. DDA site visits related to incident reports and health and welfare concerns; and

2. The Office of Health Care Quality surveys to ensure they are current and comply with regulations and during complaints and incident investigations.

In addition, a representative sample of Person-Centered Plans are reviewed by the Quality Improvement Organization. A representative annual sample of waiver participants plans are reviewed with a confidence interval of = 95% +/-5%. This sampling method means DDA can be 95% sure that the true results for all waiver participants' service plans are within 5% above or below what is found in the sample reviews (a total range of 10%). This allows findings and recommendations to be generalized to all service plans of waiver participants. Data is collected and reported quarterly.

The PCPs are maintained in the LTSSMaryland System. Records are maintained for 7 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

LTSSMaryland retains copies of the PCPs. Information is retained in LTSSMaryland under the Programs > POS/PCP/POC module. The LTSSMaryland system currently maintains the full history of documents.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

State staff and Maryland Department of Health agents will conduct site visits, perform utilization reviews, and follow up on health and welfare concerns. In-person health, welfare, and service monitoring visits from Coordinators of Community Services and Maryland Department of Health staff assess the participant's services and 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 of the participant.

(a) The Entity (Entities) Responsible For Monitoring Implementation of Service Plan and Participant Health & Welfare

The CCS and the DDA monitor the implementation of the PCP to ensure that Waiver program services are delivered in accordance with the PCP and consistent with safeguarding the participants' health and welfare.

Access to non-waiver services:

The person-centered planning process includes the exploration and discovery of important relationships, community connections, faith-based associations, health needs, areas of interest, and talents that can also help identify additional potential support for desired outcomes.

The PCP Outcome page in LTSSMaryland includes a description of how community resources and natural supports (i.e., non-Waiver services) are being used or developed. The CCS PCP Guide provides direction for the CCS on how to identify and describe opportunities for people to utilize their natural supports, including non-staff supports to engage in the Outcome-related activities and to include use of generic community resources (e.g., using a store-provided shopping aide or having staff focus on developing relationships with coworker's versus providing actual on-the-job assistance). All natural, community, and other contributing resources to support the outcome are listed under the Supports Considerations chart of the Outcome section.

In addition, Community Living–Group Home and Community Living–Enhanced Support services are delivered by provider-owned or leased and operated residential habilitation sites. These providers are responsible for supporting the participant to attend their health appointments and for follow-up actions based on results and the documentation of said events. This information must be provided to the Coordinator of Community Services.

(b) Methods for Monitoring and Follow-Up Activities

The PCP format based in LTSSMaryland also includes information related to how the team will know that progress is occurring and the frequency for assessing satisfaction, the implementation strategies, and reviewing the outcome.

The CCS is required to conduct quarterly monitoring and enter information into the LTSSMaryland Monitoring and Follow Up form. The form includes sections related to demographic information, contacts, date of visit, any changes in status, service provision, participant satisfaction, progress of outcomes, and health and safety. Based on data entry in these sections, follow-up action may be required and will be noted in the "Recommended Action" section which can include items specific to service provision. Health and safety items require immediate action and, in some situations, require an incident report as per the PORII which is described in Appendix G.

The CCS's monitoring activities are designed to provide support to participants and their families and encourage frequent communication to address current needs and to ensure health and safety. In addition, monitoring facilitates increased support to plan for services throughout the participant's lifespan. The monitoring maximizes support to create the quality of life envisioned by the participant and the family.

The CCS's monitoring activities verify that the participant is receiving the appropriate type, amount, scope, duration, and frequency of services to address the participant's assessed needs and desired outcome statements as documented in the approved PCP. It also ensures that the participant has access to services, has a current back-up plan, including an emergency plan, and exercises free choice of providers. When changes in a participant's needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increased monitoring may be warranted based on participant's health and safety needs.

The CCS conducts these monitoring and follow-up activities through multiple and various sources, not limited to, service

and environmental observation, LTSSMaryland service reports, incident reports, provider training and activity logs, and through conversations with the participant, their legally authorized representative, (as applicable), other identified planning team members, and service providers. The CCS is required to conduct an in-person, face-to-face, visit with the participant enrolled in services at least once per quarter as per DDA requirements.

The CCS must enter information regarding these monitoring activities and follow-up actions into the LTSSMaryland Monitoring and Follow-Up form. Health and safety concerns must be reported per the Policy of Reportable Incidents and Investigations and included in the Monitoring and Follow-Up form.

The DDA monitoring activities include:

1. Regional Offices monitoring implementation of the PCP through the review and approval of service plans and authorizations of services revisions are made to address changing needs of the participants;

2. Regional Offices conducting onsite reviews of participant services and providers implementation including elements related to staff knowledge of services, service delivery as noted in the PCP, and health and welfare (e.g., medication administration records and health assessments completed); and

3. Regional Offices monitoring the quality of the CCS monitoring services related to the implementation of the service plan.

To oversee and assess CCS activities, Monitoring and Follow Up forms are automated in the LTSSMaryland system and are required to be completed by the Coordinator of Community Services. The DDA has implemented a CCS squad within each Regional Office who are responsible for providing technical assistance and oversight to CCS agencies. The DDA has also contracted with a Quality Improvement Organization (QIO) to facilitate CCS billing audits and quality assurance reviews of PCPs and monitoring and follow up. These audits and quality assurance reviews will result in a Plan of Correction (POC), as applicable. The QIO will ensure any POC is completed and satisfied.

The LTSSMaryland Monitoring and Follow-Up Report provides both the DDA and CCS agencies information related to the completion status of the Quarterly Monitoring and Follow-up forms for each person served. This functionality enables the DDA to improve its oversight and review of CCS activities. The DDA regional offices and Headquarter CCS leadership regularly meet with each CCS provider to review applicable data related to the completion and timely submission of PCPs and Monitoring and Follow-Up form. The regional offices are tracking and monitoring PCP and monitoring and follow-up completion on a weekly basis and following up with applicable CCS agencies as necessary.

Each CCS will review evidence of satisfaction with services, service goal implementation, ensure the person is healthy and safe, and if there are any changes in the person's need, such as support with maintaining Medicaid eligibility. This must be documented in LTSSMaryland's Monitoring and Follow-Up form and include whether progress has been made for people on their caseload, what they used to verify, and where the in-person visit occurred. They will also review necessary documentation to verify the provision of services as authorized. If there is insufficient progress, the CCS Coordinator of Community Services will follow-up with the service provider to determine why progress is not being made. The Coordinator of Community Services will coordinate and assess needed services and supports with the participant and their team and when applicable refer and support with any relevant natural, community, State and federal resources, services and supports.

The QIO will also review a sample of the quarterly Monitoring and Follow-Up forms. Applicable follow up with CCS will occur as necessary.

Based on DDA's monitoring activities, action is taken on all immediate jeopardy findings and technical assistance, training, and/or POCs are initiated.

(c) The Frequency With Which Monitoring Is Performed

DDA's monitoring frequency include:

1. Regional Offices monitoring implementation of the PCP on a periodic basis through the approval of service plans and

authorizations of services revisions are made to address changing needs of the participants;

2. Regional Offices in collaboration with the QIO performing onsite reviews of participant services and providers varies and includes: (a) initial or routine visits to provider sites, (b) review of a filed complaint, (c) provider POC follow-up, (d) review of a reported incident; (e) Technical Assistance; (f) service request review; and

3. Regional Offices and QIO monitoring the quality of the CCS monitoring of PCP implementation.

The DDA reviews back-up plans with emergency requests for services, and as part of Regional Office Quality Enhancement and Quality Enhancement - Regional Nurse health and safety site visits.

As part of the Council on Quality and Leadership Basic Assurances, the Quality Improvement Organization evaluates if provider organizations support people to have individualized emergency plans. This evaluation includes: types of emergencies, modifications for support, staff training, and how the organization uses data from safety drills to assess effectiveness. During Personal Outcome Measures conversations, the Quality Improvement Organization discusses outcomes and supports people's experiences related to living and working in environments that meet expectations for safety, sanitation and emergency evacuation.

In addition, the National Core Indicators surveys, collect participant and family satisfaction data related to back up planning and emergencies for the following questions:

1. If you asked for crisis or emergency services during the past 12 months, were services provided when needed?

2. Do you feel prepared to handle the needs of your family member in an emergency such as a medical emergency or natural disaster?

3. Have you talked about how to handle emergencies (such as a medical emergency, pandemic or natural disaster) with your family member’s case manager/service coordinator?

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP – PM1 - The number and percentage of participants who report their service plan includes things that are important to them. Numerator = Number of participants who report their service plan includes things that are important to them. Denominator = Number of participants surveyed who have a valid response.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Sampling Requirements

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% +/- 5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

SP – PM2 - Number and percentage of service plans that address identified risks. Numerator = Number of service plans that address identified risks. Denominator = total service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or Quality Improvement Organization Targeted Case Management Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP - PM3 - Number and percentage of service plans that document exploration of other non-DDA services. Numerator = Number of service plans that document exploration of other non-DDA services. Denominator = total service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Targeted Case Management Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

Quality Improvement Organization		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP - PM4 - Number and percentage of service plans reviewed and updated before the participants annual review date. Numerator = Number of service plans reviewed and updated before the participants annual review date. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or Quality Improvement Organization Targeted Case Management Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP – PM5 - Number and percentage of participants who report their staff come and leave when they are supposed to. Numerator = Number of participants who report their staff come and leave when they are supposed to. Denominator = Number of participants surveyed who have a valid response.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Sampling Requirements

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP – PM6 - Percentage of participants who report they helped make their service plan. Numerator = Number of participants who report they helped make their service plan. Denominator = Total number of participants surveyed who have a valid response.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Sampling Requirements

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

QIO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Per 2014 guidance, states no longer have to report on this sub-assurance

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: N/A	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: N/A	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: N/A

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The DDA's Quality Enhancement staff provides oversight of planning activities and ensures compliance with this Appendix D related to waiver participants.

The DDA's Coordination of Community Services staff provides technical assistance and support on an ongoing basis to Coordination of Community Services providers and provides specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used, including Coordination of Community Services provider training, partnering with the DDA Provider Services staff to provide additional communication with, and training to providers. Remediation efforts will be documented in the provider's file with the DDA.

The DDA and the Coordination of Community Services and providers report issues with LTSSMaryland functionality to a centralized help desk. The DDA, the Office of Long Term Supports and Services, and LTSSMaryland consultants meet weekly to review and prioritize system-related issues.

To improve compliance with the performance measure, the Quality Improvement Organization will evaluate the provision of services, remediate problems with quality, design quality enhancement strategies, and deliver continuous quality enhancement for statewide services extending internal capabilities. The Quality Improvement Organization will assess whether services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan (i.e., utilization reviews). The Quality Improvement Organization in collaboration with the Council on Quality and Leadership conducts Personal Outcome Measure interviews with participants and Basic Assurance interviews with providers to collect and analyze information regarding individual and systemic deficiencies. The Quality Improvement Organization also conducts the National Core Indicators Survey in an effort to measure and improve the performance of DDA's service system. The Quality Improvement Organization shares findings with DDA and provides

recommendations on remediation and overall quality enhancement. DDA considers recommendations and has made updates to improve policies, waiver proposals, including improving performance measures based on this data.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take

advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

A participant and their legally authorized representative, (as applicable) may direct their own services or authorize a designated representative to direct on their behalf within the Self-directed Service Delivery Model. Participants are supported in making decisions regarding how services are provided while ensuring there is: (1) no lapse or decline in the quality of care; and (2) no increased risk to the health or safety of the participant.

(a) Nature of Opportunities Afforded to Participants

Participants and their legally authorized representative, (as applicable) has decision–making authority as the employer of record, including Employer and Budget Authorities.

The participant and their legally authorized representative, (as applicable) have direct responsibility for management of the participant's services and meeting program requirements. This includes the rights and obligations of an employer under applicable federal, State, and local law and regulations. In addition, the participant and their legally authorized representative, (as applicable) have the responsibility and authority over how funds in a budget are spent within program rules and the total approved annual budget. With budget authority, participants have choice and control over needed long-term services and supports that help to maintain and improve the participant's health and quality of life in their community.

Participants may also seek support with decision making. Supported decision making means a process by which an adult, with or without having entered a supported decision–making agreement, utilizes support from a series of relationships in order to make, communicate, or put into action the adult's own life decisions. Individuals that support the participant with decision making, do not make decisions for the participant.

The participant and their legally authorized representatives, with the support of their person-centered planning team, will have opportunities, within program limits, to:

1. Identify goals to support a trajectory for a good life in consideration of person-centered planning methodologies, such as the Charting the LifeCourse (i.e., Integrated Support Star, Life Trajectory, and Exploring Life Possibilities), Integrated LTSS – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent Person-Centered Plan strategy;

2. Make choices about and direct all aspects of their lives, including by choosing and controlling the delivery of waiver services, who provides services, and how services are provided;

3. Identify needed supports and services to include in their Person-Centered Plan in accordance with their approved annual budget;

4. Set compensation (including wages and benefit rates) within a reasonable and customary range and the DDA-approved annual budget.

5. Choose, recruit, train, hire, schedule, supervise, and discharge employees, vendors, and DDA providers that furnish their services;

6. Control and manage an annual budget for the purchase of services and supports, as specified in their approved Person-Centered Plan;

7. Use an approved Medicaid Support Broker provider as an optional service to assist with employer related information and advice as outlined in the Participant Agreement; or as a required service if employing a relative, family member, designated representative, or legal guardian, or using staff as a Day-to-Day Administrative support; and

8. Use a Financial Management and Counseling Services provider to assist with budget and payment responsibilities, which is required for participation.

(b) How Participants May Take Advantage of these opportunities;

The DDA, Advocacy Specialists, and Coordinator of Community Services will provide information about the Self-Directed Service Delivery Model to all participants and their legally authorized representatives (as applicable). If the

participant is interested in the self-directed service delivery model, they will work with their Coordinator of Community Services to organize their PCP team, develop a Person-Centered Plan, and complete the required self-direction training requirements.

Mandatory Self-Direction Training Requirement

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 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 self-directed orientation/training must be completed before enrollment. There is no cost to participants to attend.

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.

Participant Rights and Responsibilities and Self-Directed Services Participant Agreement Form

The Coordinator of Community Services and Support Broker, with input from the participant's team, will share information with the participant about the rights, risks, and responsibilities of managing their own services, and managing and using an individual budget. This process is documented with completion of the DDA Participant Rights and Responsibilities and Self-Directed Services Participant Agreement Form.

(c) The Entities That Support Individuals Who Direct Their Services And The Supports That They Provide

The following entities will provide support services to participants in the Self-Directed Services Delivery Model: the Coordinator of Community Services, the DDA Regional Office Self-Directed Services Leads, Advocacy Specialists, Support Brokers, and the Financial Management and Counseling Services provider.

The Coordinator of Community Services will provide supports that enable the participant to identify and address how to meet their needs and goals, including but not limited to:

1. Providing information to the participant to support informed decisions about natural supports, community resources, what delivery models (Self-Directed Services and Provider Managed), and service and service provider options (employees and DDA providers) that will work best for the participant and their support network in accordance with their needs and goals;

2. Providing information related to Medicaid waiver program services available under the Self-Directed Services Delivery Model, including Support Broker and Financial Management and Counseling Services provider services, and employee and providers/vendor options for the participant to choose;

3. Explaining roles and responsibilities of the participant, Support Broker and the Financial Management and Counseling Services provider, employer and budget authorities' responsibilities, and the participant agreement pertaining to the types of available supports within the Self-Directed Services Delivery Model;

4. Facilitating the timely development and revision of the Person-Centered Plan and Self-Directed Services budget designed to meet the participant's needs, preferences, goals, and outcomes in the most integrated setting and cost-effective manner;

5. Providing information, making referrals, and assisting participants with applications for services provided by community organizations, federal, State and local programs and community activities; and

6. Monitoring the provision of services and conducting related follow-up activities.

DDA Regional Office Self-Directed Services Leads

1. The DDA Regional Office Self-Directed Services Leads provide technical assistance to participants who self-direct and their teams.

2. Technical assistance can include:

a. Supporting participants and their teams to understand Medicaid waiver requirements and the rights/responsibilities of self-direction; and

b. Clarification requests of Person-Centered Plan and documents.

3. The Regional Office Self-Directed Services Lead can also support participants and teams to mitigate conflicts of interest by providing feedback to the annual Participant Agreement and other Person-Centered Plan documents.

Advocacy Specialists provide informational supports for participants considering or enrolled in the Self-Directed Service Delivery Model, including:

1. Providing information and technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State;

2. Facilitating and building relationships with self-advocates, self-advocacy groups and providers;

3. Supporting other self-advocates to learn about and understand DDA's Self-Directed Service Delivery Model;

4. Providing general support to participants enrolled in Self-Directed Service Delivery Model; and

5. Developing and conducting additional topic specific training that meets the needs of Self-Directed Services participants in their regions, such as incident reporting, fraud, waste, abuse, neglect, exploitation, and nepotism.

Support Broker Services

Support Broker services are outlined in Appendix C. Support Brokers provide assistance by mentoring and coaching the participant on their responsibilities as a common law employer related to staffing as per federal, State, and local laws, regulations, and policies. A Support Broker works at the direction of and for the benefit of a participant who uses Self-Directed Services. Support Brokerage service is used to:

1. Provide information to ensure that participants understand the responsibilities involved with directing their services; and

2. Assist the waiver participant in developing the skills necessary to independently direct and manage their Medicaid waiver services and providers (including employees, vendors, and DDA Providers) as the employer of record.

CONTINUED IN MAIN-B. OPTIONAL DUE TO SPACE LIMITATIONS**********

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's

representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participant direction opportunities are available to participants who live with other individuals under a lease or Shared Living Waiver service arrangement.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The Self-Directed Services Participant’s Agreement must be completed that documents both the participant’s request for assistance in self-directing their services, and the team members’ agreement to assist and support with the specific work or tasks described in this Agreement.

Effective October 6, 2025, participants selecting the Self-Directed Services Delivery Model must complete the required self-directed services training requirement.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Coordinator of Community Services is responsible for providing information to the participant and their legally authorized representative, (as applicable) about available program services and delivery models, including the Provider Managed and Self-Directed Services Delivery Models. The Coordinator of Community Services provides information on availability of services, benefits, responsibilities, and liabilities associated with participation in the Self-Directed Service Delivery Model. The Coordinator of Community Services provides this information during the initial meeting, the annual Person-Centered Planning Meeting, and upon request. The Coordinator of Community Services will document the participant's service delivery model choice on the initial Freedom of Choice Form. In addition, the Coordinator of Community Services will attest to informing the participant of their right to choose the service delivery model (either the Self-Directed Services Delivery Model or Provider Managed Model) on the Person-Centered Plan signature sheet. The participant and their legally authorized representative, (as applicable) also attest that they understand the participant is free to choose the service delivery model (either the Self-Directed Services Delivery Model or Provider Managed Model) on the Person-Centered Plan signature sheet.

The DDA also provides information about its Self-Directed Service Delivery Model via training, webinars, workshops, conferences, the DDA's website, and upon request.

The DDA or its designee also provides training on self-direction which will include information regarding rights, roles, responsibilities, and processes including the development of the individual's budget and modifications.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Adult participants enrolled in the Self-Directed Service Delivery Model (as provided in this Appendix E) may authorize a non-legal representative to direct services on their behalf as documented on the DDA Self-Directed Services Participant Agreement.

The Self-Directed Services Participant's Agreement documents the participant's desire to self-direct their services or designate a representative to direct their services.

Requirements of the Agreement include:

1. The participant's Coordinator of Community Services must assist the participant and their legally authorized representative, (as applicable) to complete this agreement per the participant's preferences and best interests.

2. The Coordinator of Community Services must assist the participant and their legally authorized representative, (as applicable) to update this agreement when any changes are requested by the participant or their legally authorized representative, (as applicable).

3. The Coordinator of Community Services must review this document with the participant on a quarterly basis to confirm the continued accuracy of the agreement.

Safeguards To Ensure That A Non-Legal Representative Functions In The Best Interests Of The Participant:

1. The Coordinator of Community Services are responsible for monitoring the implementation of the Person-Centered Plan on an ongoing basis. The Coordinator of Community Services also monitors that the services and supports meet the participant's privacy, health and safety needs, and that the participants remain satisfied with their services and supports including the use of a representative for directing services.

2. Coordinator of Community Services and Financial Management and Counseling Services providers reports concerns to the DDA Regional Office when representatives do not appear to be functioning in the best interests of the person. Coordinator of Community Services and team members support participants in identifying new representatives as applicable.

3. Coordinators of Community Services also submit incident reports including but not limited to abuse, neglect, and exploitation as per the Policy on Incidents and Investigation.

4. DDA and the Office of Health Care Policy review and investigation incidents as per the Policy on Incidents and Investigation.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Vehicle Modifications	☐	☒
Supported Living	☐	☒
Shared Living	☐	☒
Support Broker Services	☒	☒
Transition Services	☐	☒
Remote Support Services	☐	☒
Respite Care Services	☒	☒

Waiver Service	Employer Authority	Budget Authority
Family Caregiver Training and Empowerment Services	☐	☒
Housing Support Services	☐	☒
Individual and Family Directed Goods and Services	☐	☒
Live-in Caregiver Supports	☐	☒
Nursing Support Services	☒	☒
Participant Education, Training, and Advocacy Supports	☐	☒
Personal Supports	☒	☒
Day Habilitation	☐	☒
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	☐	☐
Employment Services	☒	☒
Environmental Assessment	☐	☒
Environmental Modifications	☐	☒
Family and Peer Mentoring Supports	☐	☒
Transportation	☒	☒
Assistive Technology and Services	☐	☒
Behavioral Support Services	☐	☒
Community Development Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Providers approved by the DDA as an OHCDS in accordance with applicable State regulations provide this service. Providers are identified through the MDH request for proposal procurement processes.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMCS is compensated for administrative activities as per their contract with the MDH. As per COMAR 10.22.17.13, the cost of services are to be deducted from the participant's Medicaid Waiver self-directed budget.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Employer and Budget Authorities tasks including but not limited to:

1. Verifying that potential staff, vendors, and DDA Medicaid providers meet applicable qualifications including background checks, certifications, trainings and licensing requirements;

2. Managing and directing the disbursement of funds contained in the participant's SDS budget sheet;

3. Acting as a neutral bank, receiving and disbursing public funds, and tracking and reporting on the status of each participant's budgeted funds (received, disbursed, and any balances);

4. Processing and paying invoices for approved services in the PCP;

5. Ensuring that all payments meet program standards;

6. Preparing and distributing reports (e.g., budget status and expense reports) to participants, their CCS, the DDA, and other entities as requested; and

7. Provide timely responses and resolutions to participant requests.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed**

budget

☒ **Other services and supports**

Specify:

1. The Financial Management and Counseling Services provider assists the participant and their legally authorized representative or designated representative (as applicable) to:

a. Manage and direct the disbursement of funds contained in the current approved annual self-directed budget allocation;

b. Facilitate the employment of staff by the participant and their legally authorized representative, or designated representative (as applicable), by performing as the participant's agent to verify employee and vendor qualifications, processing payroll, withholding Federal, State, and local tax and making tax payments to appropriate tax authorities; and

c. Perform fiscal accounting and disseminate expense reports to the participant and their legally authorized representative, or their designated representative (as applicable), State authorities, and other entities as requested.

2. The Financial Management and Counseling Services provider assists the participant, participant's legal guardian and their legally authorized representative, or designated representative (as applicable) with Budget Authority tasks such as:

a. Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the status of the participant's budgeted funds (received, disbursed and any balances);

b. Maintaining a separate account for each participant's self-directed budget;

c. Tracking and distributing a participant's funds, as approved by the DDA and in accordance with Medicaid waiver program requirements;

d. Ensuring that the participant stays within their budget and managing cost savings, including unallocated funds for approved goods and services as per program requirements;

e. Processing and paying invoices for Medicaid waiver program services in accordance with the DDA's authorization; and

f. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, the DDA, and other entities as requested.

g. Additional functions/activities, such as providing other entities specified by the State with periodic reports of expenditures and the status of the self-directed budget.

3. The Financial Management and Counseling Services provider provides timely responses and resolutions to participant requests.

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMCS provider is required to obtain annual independent financial audits.

On an annual basis, the DDA or its designee will conduct a representative sample review of SDS participants' budgets, billing, and payments.

If there are concerns about billing, the FMCS provider may be referred to the DDA and/or OLTSS staff, or to the Department's Internal Audit and Control (IAC) staff. A referral may also be made to Maryland's Medicaid Fraud Control Unit, which may conduct audits when there is a strong likelihood of fraud.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

A participant, enrolled in either Self-Directed Services or Provider Managed Services Delivery Models, must receive Targeted Case Management services from a Coordinator of Community Services. The Coordinator of Community Services provides supports to the participant, and their legally authorized representative to help them identify all of their strengths and unique abilities to achieve self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. This includes learning about options under the DDA's Self-Directed Service Delivery Model, planning for the participant's future, and accessing needed services and supports. The Coordinator of Community Services promotes services that are planned and delivered in a manner that are timely executed to meet the participant's needs as stated in their Person-Centered Plan and encourages self-sufficiency, health and safety, meaningful community participation, and the participant's desired quality of life.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modifications	☐
Supported Living	☐
Shared Living	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment (phased out effective years 3, 4, and 5)	☐
Support Broker Services	☒
Transition Services	☐
Remote Support Services	☐
Respite Care Services	☐
Family Caregiver Training and Empowerment Services	☐
Housing Support Services	☐
Individual and Family Directed Goods and Services	☐
Live-in Caregiver Supports	☐
Medical Day Care	☐
Nursing Support Services	☐
Participant Education, Training, and Advocacy Supports	☐
Personal Supports	☐
Community Living - Enhanced Supports	☐
Community Living - Group Home	☐
Day Habilitation	☐
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	☐
Employment Services	☐
Environmental Assessment	☐
Environmental Modifications	☐
Family and Peer Mentoring Supports	☐
Transportation	☐
Assistive Technology and Services	☐
Behavioral Support Services	☐
Career Exploration	☐
Community Development Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or

entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Advocacy Specialists:

1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State;
2. Provide feedback to the DDA staff on communications with participants in the DDA's SDS delivery model;
3. Build relationships with self-advocates, self-advocacy groups, and providers;
4. Provide and support other self-advocates to learn about and understand the DDA's SDS delivery model;
5. Provide general support to people receiving SDS from the DDA; and
6. Develop and conduct additional training that meets the needs of Self-Advocates in their regions.

Advocacy Specialists participate in various DDA trainings, committees, and workgroups; provide one-to-one information and technical assistance; provide one-to-one advocacy services; and make frequent contact with the CCS in order to assist participants seeking advocacy services related to the SDS delivery Model.

PARTICIPANT ACCESS

Participants may contact the Advocacy Specialists via telephone or email or at trainings to obtain advocacy services. The independent Advocacy Specialists are available to provide assistance to address an issue of concern, training, technical assistance, and other advocacy services to participants currently directing their own services or interested in self-directing their services. The Advocacy Specialists provide information, technical assistance, and advocacy via the internet, telephone, or in-person, as requested.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The participant, or their legally authorized representative, (as applicable) may choose to terminate the participant's enrollment in the Self-Directed Service Delivery Model at any time, without cause, in order to enroll and receive services under the Provider Managed Services Delivery Model, directly from a provider.

In order to terminate participation in the Self-Directed Service Delivery Model and transition to the Provider Managed Services Delivery Model, the participant and their legally authorized representative, (as applicable), must notify the participant's Coordinator of Community Services. The Coordinator of Community Services will assist the participant transitioning to the Provider Managed Services Delivery Model and selecting licensed/certified provider(s) to provide services. The Coordinator of Community Services will work with the participant and their legally authorized representative, (as applicable), and the participant's team to explore service options and develop a transition plan that includes strategies that ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

While enrolled in the Self-Directed Service Delivery Model, participants and their legally authorized representative, (as applicable), along with their team, or their designated representatives (as applicable) are required to comply with the requirements set forth in this Medicaid waiver program application and all applicable federal, State, and local laws, regulations, and Department policies and procedures.

The DDA has the authority to terminate the participant's enrollment in the Self-Directed Service Delivery Model, without the ability to reapply for or enter the Self-Directed Service Delivery Model for any length of time, if one of the following circumstances occurs:

1. The participant no longer meets eligibility criteria for the waiver;

2. The participant's Person-Centered Plan has not been submitted to the DDA (for DDA's review and approval) in a timely manner and this failure is attributable to the participant, their team, legally authorized representative, legal guardian, or their designated representative;

3. The participant does not receive services under the Self-Directed Service Delivery Model, in accordance with the participant's Person-Centered Plan and annual budget, for 90 days or more, with the exception of extenuating circumstances;

4. The health, safety, or welfare of the participant is compromised by continued participation in the Self-Directed Service Delivery Model;

5. The rights of the participant are being compromised;

6. Failure of the participant, their team, legally authorized representative, legal guardian, or the participant's designated representative (as applicable) to comply with any applicable federal, State, or local law, regulation, policy, or procedure; or

7. Failure of the participant, their team, legally authorized representative, legal guardian, or the participant's designated representative (as applicable) to manage funds within the participant's DDA-approved annual budget, including expending or attempting to expend funds inconsistent with the DDA-approved annual budget.

8. The participant overutilizes authorized services.

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.

In the event the DDA terminates the participant's enrollment in the Self-Directed Service Delivery Model in accordance with this section, 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:
1. The date and basis of the DDA's determination; and
2. The participant's right to a Medicaid Fair Hearing as described in Appendix F.

The Coordinator of Community Services shall work with the participant and their legally authorized representative, their legal guardian or their designated representative (as applicable), and their person-centered planning team to develop a transition plan to include strategies to ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1939
Year 2		2049
Year 3		4400
Year 4		4500
Year 5		4550

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost of criminal background checks are paid by the FMCS provider.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method to conduct background checks is the same background check method as described in C-2a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

A participant's self-directed budget allocation will be determined annually through a person-centered planning process and demonstrated assessed need. The participant's self-directed budget will encompass all services in their PCP.

During the initial, revised, and annual PCP planning processes, the participant's self-directed budget will be determined based on the approved LTSSMaryland PCP detailed service authorization. The LTSSMaryland PCP detailed service authorization form includes all available services and associated rates based on the Traditional Service Delivery Model. The required use of the LTSSMaryland Person-Centered Plan detailed service authorization for participants, enrolled in either the Self-Directed Services or Provider Managed Traditional Services Delivery Models, ensure fair and equitable funding regardless of the service model chosen.

Information regarding the PCP development and authorization process and budget methodology for participant-directed budgets is available on the DDA's website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The CCS and SB will share information about the Medicaid waiver program, to include the various services and supports and budget caps. Once the PCP is completed, the DDA reviews and authorizes the PCP based on the participant's needs. The DDA sends notice to the participant and their legally authorized representative, legal guardian or designated representative (if applicable) of the final authorized budget.

The self-directed budget is based on the assessed service need documented in the initial and Annual PCP, and self-directed services rates. If there is a new health and safety service need assessed, the participant, along with their team, legal guardian, or their designated representative (as applicable) notifies the CCS. The CCS will revise the PCP and associated documents to reflect the health and safety requested service(s) which is then submitted to the DDA Regional Office for review. If approved, the revised PCP and associated budget allocation is then used to revise the self-directed budget sheet, which is provided to the team and FMCS.

If the DDA denies the request for a Medicaid waiver program service, the participant has the right to request a Medicaid Fair Hearing as described in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants may move funding across approved budget service lines as per the DDA policy and guidance.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The participant, along with their team, their legal guardian, or their designated representative (as applicable), with the support of the CCS, and the FMCS provider, will monitor funds spent on services and the projected spending for the participant's PCP year. The FMCS provider will provide real time web-based access to expenditure reports to the participant, and their legal representative (as applicable), and Coordinator of Community Services with information related to expenditures and current budget balance.

The Coordinator of Community Services will conduct quarterly or more frequently site visits including wellness checks. The DDA regional office staff including Quality Enhancement and Nurses will conduct site visits to follow-up on health and safety concerns and reported complaints and incidents.

The Office of Health Care Quality will conduct site visits and investigations based on complaints and incidents reported.

The DDA or its designee will monitor:

1. The FMCS provider for proper allocation of funding and services provided; and
2. The participant, along with their team, legal guardian, and their designated representative (as applicable) for possible over- and under-utilization of services.

The use of a multi-layered review process ensures that potential budget problems are identified on a timely basis. When over-utilization or under-utilization is "flagged," the CCS or their FMCS provider contacts the participant, along with their team, and their legal guardian or designated representative (as applicable) to assess the reasons for over-utilization or under-utilization and whether technical assistance, further training, or changes in the plan and budget, such as a reprioritization of services, are required.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative)

is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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 types of decisions or actions of the DDA and Maryland Department of Health for which there is a right to a Medicaid Fair Hearing are described in 42 Code of Federal Regulations § 431.220; Maryland Annotated Code Health-General Article § 7-406; and Code of Maryland Regulations 10.01.04. Specifically, an individual will have an opportunity for a Medicaid Fair Hearing if they bring a claim that:
1. Their application for eligibility for this Medicaid waiver program was denied;
2. They dispute the DDA's determination of their priority on the waiting list;
3. The DDA or Maryland Department of Health did not provide a determination on their application within 60 days from the date of application;
4. Their request for services has been erroneously denied or not acted upon with reasonable promptness; or
5. The DDA or Maryland Department of Health acted erroneously towards a program recipient. See Maryland Annotated Code Health-General Article § 7-406; and Code of Maryland Regulations 10.01.04.02.

Upon making a decision affecting an individual's receipt of services funded by the Medicaid waiver program, the Maryland Department of Health provides a written letter notifying the individual of its adverse decision including Notice: Medicaid Fair Hearing Rights, as further described below. A copy of the final, signed notice is retained in the individual's file in LTSSMaryland.

To ensure the individual is informed of their rights, this letter is mailed to the individual's address of record, and, if applicable, their legal representative, and specifies:
1. The Maryland Department of Health's decision,
2. The legal and factual basis of the Maryland Department of Health's decision;
3. An explanation of the individual's right to appeal the decision by requesting a Medicaid Fair Hearing ("an appeal") as explained in an enclosed notice; and
4. Their right to continue to receive services pending the appeal.

The Coordination of Community Services and authorized representatives are copied on this letter to the individual. This letter is designed to be understandable so that individuals and their families have a full understanding of the applicant's or participant's rights.

The notice of the applicant's or participant's rights in a Medicaid Fair Hearing that is enclosed with the Maryland Department of Health's decision letter is entitled, Notice: Medicaid Fair Hearing Rights. This form describes:
1. How to request a hearing;
2. The timeframe within which the hearing must be requested;
3. What a Medicaid Fair Hearing is;
4. That the individual may represent themself or use legal counsel or appoint an Authorized Representative pursuant to Code of Maryland Regulations 10.01.04.12; and
5. How to settle some (or all) of the issues in the appeal without having to go to hearing, including the option of a Case Resolution Conference as described in Appendix F-2 below.

The Maryland Department of Health has a dedicated website - "Request a Fair Hearing. File an Appeal" that includes plain 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
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.

If an individual requires assistance in pursuing a Medicaid Fair Hearing, their Coordinator of Community Service will assist. Per DDA's policy, a Coordinator of Community Services can provide the following assistance to an individual in the appeal process:

1. Explain the appeal process to an individual, family, guardian, or authorized representative;
2. Assist with the completion of the required forms for appealing a DDA determination; and
3. Assist the individual in completing and sending a request for reconsideration.

A Coordinator of Community Services cannot provide legal advice or assist in preparing for, facilitate, or represent the individual in a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

• **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The DDA also offers a dispute resolution process called a Case Resolution Conference (CRC), where the applicant or participant, their legal representative and/or other individuals supporting the applicant or participant with their consent (if applicable), and the DDA engage in discussions surrounding the decision or action in question. A Case Resolution Conference is offered for DDA's eligibility determination. A Case Resolution Conference provides an opportunity for an applicant/participant, their family, and their legal representatives to speak directly with the DDA staff to resolve a dispute before their Medicaid Fair Hearing. Only one Case Resolution Conference is available per matter is requested. The individual is informed that a Case Resolution Conference is not required prior to or as a substitute for a Medicaid Fair Hearing.

Not all issues can be resolved in the Case Resolution Conference process. If there is partial agreement, that agreement will be recorded and, if the case goes to the Medicaid Fair Hearing, only the remaining issues will be decided by the Maryland Office of Administrative Hearing (OAH). If there is no agreement, the participant and their family and/or legal representatives (if applicable) may proceed to a Medicaid Fair Hearing.

Notification of Opportunity for a Case Resolution Conference & Requesting a Case Resolution Conference

All applicants/participants and their families and/or legal representatives (if applicable) are informed of the opportunity to engage in the Case Resolution Conference process when they receive the letter from the DDA informing them of an adverse action pertaining to the DDA eligibility determination. If the applicant or participant selects it, the DDA schedules the Case Resolution Conference prior to the Medicaid Fair Hearing.

Attached to the letter from the DDA are two documents:
1. Notice: Medicaid Fair Hearing Rights; and
2. A Hearing Request Form.

In addition to describing the Medicaid Fair Hearing process, the Notice: Medicaid Fair Hearing Rights describes the Case Resolution Conference process and informs the applicant or participant of their opportunity to request a Case Resolution Conference.

The Hearing Request Form includes a box to check if the applicant or participant wants to have a Case Resolution Conference as well as a Medicaid Fair Hearing.

Case Resolution Conference Discussion

The Case Resolution Conference is a forum in which the parties engage in discussion in order to reach some resolution as to the underlying matter. The following are potential areas of discussion:

a. The positions of the applicant/participant and the DDA, and the bases for them;

b. Whether the information submitted is sufficient for the DDA to make a determination on the request; and

c. Whether the applicant/participant and the DDA are correctly interpreting and applying statutes, regulations, and policies to the facts presented.

Case Resolution Conference Structure & Processes

The Case Resolution Conference typically lasts approximately 1 hour, and the overall structure of the Case Resolution Conference is as follows:

a. The moderator, a staff member of the DDA who was not involved in the initial decision, introduces themselves and explains the process.

b. The applicant/participant and their family and/or legal representatives (if applicable), have 10 minutes to explain the request, and why they think it should be granted.

c. The DDA Regional Office representative has 10 minutes to explain why the request was denied.

d. If the moderator thinks that the facts are not clear, or are misunderstood, they may ask that the parties discuss the facts at that time, so that everyone is working with the same set of facts. If this discussion resolves some or all of the disputes, the moderator summarizes the parties' areas of agreement and documents them.

e. If there are disputes still remaining, the moderator may meet separately with the applicant/participant (and any representative) and with the Regional Office representative (referred to as "separate sessions"). In each of these separate sessions, the moderator may explain and discuss the law, regulations, and policies that apply to the services requested, and may discuss whether they believe that the facts meet the criteria and why. The other person(s) will also discuss why they believe the facts do or do not meet the criteria, and why. The moderator may ask the parties to consider other facts or policies, but the final decision on whether there is any agreement belongs to the parties in dispute, rather than the moderator. Each separate session is limited to 10 minutes.

Nothing that is discussed in the separate sessions is revealed to the other side without the expressed approval of the parties in that session. This allows all parties to be completely open with their comments and questions, without concern that the other party will hear those comments and questions. Also, during the Case Resolution Conference, the DDA Regional Office representatives may call or consult with their supervisors at any time to discuss any issue, and the moderator may call any DDA staff for clarification of policy or other matter.

f. In the remaining time, the parties meet together, with the moderator, to discuss whether their positions have changed and, if so, whether there are any issues that can be resolved. If there is resolution of part or all of the disputes, the moderator reflects back the areas of agreement and documents them. The parties sign the agreement. The moderator does not sign the agreement, since it is solely between the parties.

Case Resolution Conferences are scheduled by the DDA's Operations Office. The Maryland Department of Health grants 1 Case Resolution Conference to occur before an individual's Medicaid Fair Hearing. Case Resolution Conferences usually occur at a DDA Regional Offices or other locations within a region. Separately, the Office of Administrative Hearing schedules Medicaid Fair Hearings based on requirements in Code of Maryland Regulations 10.01.04. Medicaid Fair Hearings occur at the Office of Administrative Hearing locations or locations convenient for participants, per Office of Administrative Hearing permission.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

• **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Overview of DDA's Policy on Reportable Incidents and Investigations

The DDA has established a Policy on Reportable Incidents and Investigations which requires that all providers (employees, vendors, and DDA providers) under the Self-Directed Services and Provider Managed Services Delivery Models to 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 a critical event or incident is governed by Policy on Reportable Incidents and Investigations, then the provider, who is providing services at the time of the incident, must report the event or incident in the DDA's software database called the "Provider Consumer Information System" (PCIS2). As further detailed in Policy on Reportable Incidents and Investigations (PORII), 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 DDA, the Office of Health Care Quality, and the Office of Long Term Services and Supports all have direct access to review reported events or incidents in Provider Consumer Information System2.

The PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), APS or CPS (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., MBON).

Classification of Events or Incidents

Type 1 Incidents include: abuse, (including exploitation and financial exploitation), neglect, death, hospital admissions or emergency room visits, injury, medication error, and choking. Abuse includes: physical abuse, verbal abuse, mental abuse, sexual abuse, seclusion, and any action or inaction that deprives an individual in DDA funded services of the ability to exercise their legal rights, as articulated in State or federal law.

All providers to whom PORII applies must report all Type 1 incidents to the DDA immediately upon discovery. The completed Incident Report must be received by the OHCQ, the State Protection and Advocacy agency, CCS, and the DDA Regional Office within 1 working day of discovery. In addition, the DDA providers must also complete an Agency Investigation Report (AIR) that includes updated information based on the provider's investigation of the incidents, remediation and preventive strategies, and additional services and supports that may be needed. An AIR is submitted in the PCIS2 within 10 business days of discovery of the incident. The AIR document template is found within PORII and is within the original incident report in PCIS2. An AIR includes detailed updated information based on the provider's investigation of the incident, which includes the remediation, preventative strategies, and additional supports and services that may be needed.

Type 2 Incidents include: law enforcement, fire department, or emergency medical services involvement; theft of an individual's property or funds; unexpected or risky absence; restraints; and any other incident not otherwise defined in the policy that impacts or may impact the health or safety of a person. Restraints include: any physical, chemical, or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of the PCP or those used on an emergency basis.

All providers to whom PORII applies must report all Type 2 incidents within one (1) working day to the DDA Regional Office, the participant's family/legal guardian/advocate(s), and the participant's CCS.

Internally investigated incidents are events and or situations that shall be reported within 1 working day of discovery to designated staff within the agency. The agency is responsible for reviewing and investigating each of these incidents. Types of Internally investigated incidents are outlined within Policy on Reportable Incidents and Investigations and include but are not limited to the following: physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment.

Incidents involving Participants in Home Environment

When a participant who resides with their family experiences a critical incident that jeopardizes the participant's health and safety, the CCS will seek the assistance of law enforcement and CPS or APS (as applicable), each of which has the authority to remove the alleged perpetrator or the victim from the home to ensure safety.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The CCS provides and reviews with the participant, and their legal representative and family, the participant's Rights and Responsibilities, annually. The participant's Rights and Responsibilities are generally set forth in the Maryland Annotated Code, Health-General Article Title 7, Subtitle 10, and include the participant's right to be free from abuse, neglect, and exploitation. After review with the CCS, the participant or their legal representative signs the form acknowledging receipt.

The DDA website home page includes a link to information on how to report abuse or concerns. Information can be viewed at: https://health.maryland.gov/dda/Pages/Report%20Abuse.aspx

The DDA Director of Family Supports and Regional Office Advocacy Specialists also provide information, training, and webinars related to protections and how to report.

DDA providers must ensure a copy of the PORII and the provider's internal protocol on incident management is available to participants receiving services, their parents or guardians, and advocates.

The PORII and all necessary forms are also available on the DDA website.

In addition, the COMAR 10.01.18 requires that DDA-licensed vocational and day services programs adopt Sexual Abuse Awareness and Prevention Training, including mandatory reporting requirements, for both its staff and participants.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Entities Receiving Notification of Incident Report

The DDA, the OLTSS, the OHCQ, and CCS receive notification of all Type I incidents submitted in the PCIS2 system. The DDA and CCS also receive notification of all Type II incidents submitted.

PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), CPS or APS (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., MBON). All allegations of abuse or neglect must be reported to the State's Protection and Advocacy organization, CPS or APS (as applicable), and local law enforcement (as applicable).

The provider is required to notify the participant's authorized representative(s) (e.g., family, legal guardian, etc.) that an incident report has been submitted. The authorized representative(s) of the participant may request a copy of the incident report in accordance with the State's Public Information Act.

Initial Screening

OHCQ's triage staff reviews all reported Type 1 incidents and DDA staff reviews all reported Type 2 incidents. Depending on the classification, either the DDA's or the OHCQ's staff performs an initial screening of each reported incident, within 1 working day of receipt, to determine if that incident poses immediate jeopardy to a participant and, therefore, warrants immediate investigation.

The staff reviews each report and notifies its respective supervisor – the OHCQ's DD Investigation's Unit Manager or the DDA's Regional Quality Enhancement Director – of the need to evaluate the report for appropriate assignment based on the severity and scope of the incident.

If, during the initial screening or evaluation, the DDA reviews a Type 2 incident and reasonably believes that the incident should be classified as a Type 1 incident, then the DDA will refer the incident to OHCQ for further review and possible investigation.

In addition, the content of the written report is evaluated to ensure the following information is included:

1. The participant is not in immediate danger;

2. When applicable, law enforcement and/or APS/CPS have been contacted;

3. Staff suspected of abuse or neglect have been suspended from duty;

4. The participant has received needed intervention and health care; and

5. Systemic and/or environmental issues have been identified and emergently handled.

If this information is not included in the initial report, the staff will contact the provider to ascertain the status of the participant and ensure the participant's health and safety. If the provider does not provide the information within a reasonable time frame (no later than 48 hours after the initial review of the report by triage staff), then the provider's lack of response will influence the decision to begin an on-site investigation or activity more quickly.

Evaluation of Reports

TYPE 1 INCIDENTS – OHCQ

Evaluation

The OHCQ reviews all Type 1 incidents, including those that may have been assigned on an emergency basis. The OHCQ staff performs a comprehensive review of the reported incidents. In its evaluation, the OHCQ staff takes into consideration the number and frequency of reportable incidents or complaints associated with a participant and/or attributed to the provider and the quality of the provider's internal investigations. The OHCQ staff also reviews submitted AIRs, to ensure appropriate actions were taken by the provider in response to an incident. Incidents which may have been

previously determined to not require investigation may be re-categorized based on information received in an AIR.

Investigation

The OHCQ has the authority to investigate any DDA providers on behalf of the DDA. The Office of Health Care Quality can investigate any incident or complaint that happens at DDA providers or during the delivery of funded services.

If the incident warrants further investigation, the OHCQ conducts investigations through on-site inspections, interviews, or reviews of relevant records and documents. The OHCQ initiates investigations based on the priority classification of the incident (as defined in PORII).

During the investigation of an incident, an OHCQ staff reviews the AIR and related documentation. The investigator(s) will make their best effort to interview all persons with knowledge of the incident, including, but not limited to: the participant receiving services, their guardian or family member(s), the provider's direct care and administrative staff who were involved in the incident, etc. The investigator also makes direct observations of the participants in their environment. When possible, evidence is corroborated between interviews, record reviews, and observations. Deficiencies are, to the extent practicable, cited at an exit conference held upon completion of the on-site investigation. Investigations are completed, whenever possible, within 45 working days of initiation.

The participant or their authorized representative(s) of the participant may request investigation results, documented in OHCQ's Statement of Deficiencies, in accordance with the State's Public Information Act.

Participants and representatives are informed within 10 business days of the issuing of the investigation results by the provider.

TYPE 2 INCIDENTS – DDA

Evaluation

DDA Regional Office Quality Enhancement (QE) staff review each report for completeness and for evidence of the provider's actions to safeguard the health and safety of the participant or others. In its evaluation, the DDA determines if intake information is sufficient to determine whether dangerous conditions are not present and ongoing. If, based on the review of the report, including the AIR, the DDA Regional Office QE staff is unable to determine that action has been taken by the provider to protect the participant from harm, then the DDA Regional Office QE staff will intervene. Depending on the circumstances, the DDA may intervene by contacting the provider or conducting an on-site visit.

The DDA will also evaluate the Incident report, the AIR, and any subsequent correspondence and determine appropriate DDA follow-up which may include:
1. Investigation;
2. Referring the matter to the OHCQ, law enforcement, or protective services;
3. Generalized training;
4. Provider specific training; and
5. Technical assistance.

An incident report that is incomplete or contains errors will result in a communication from the DDA Regional Office QE staff to the DDA provider requesting revision to the incident report and resubmission of a complete and correct report. When a provider reports 3 or more incidents that involve the same participant within a four-week period, the DDA will determine, based upon the provider's compliance history and nature of the incidents, whether an on-site visit is warranted.

Participants and representatives are informed within 10 business days of the issuing of the investigation results by the provider.

Incidents Outside Of A Site Or Service Licensed By MDH

When an incident is alleged to have occurred outside of a site or service licensed by MDH, the CCS and service providers

will seek the assistance of appropriate authorities for review and investigation such as local law enforcement and CPS or APS (as applicable). The OHCQ, DDA, or OLTSS may also refer the incident to the appropriate entities or jurisdictions for their review and investigation.

When indicated, incidents are referred to the Maryland Office of the Attorney General's Medicaid Fraud Control Unit for consideration of filing criminal charges. When an incident involves legal issues for the participant, it may be referred to the State's Protection and Advocacy organization.

Deaths

The OHCQ refers all reported deaths to the OHCQ's Mortality Investigation Unit for review and investigation. The OHCQ Mortality Investigation Unit evaluates death reports, determines priority for investigations, and conducts investigations using its own policies and procedures. The OHCQ Mortality Investigation Unit submits its findings to the Department of Health's Mortality and Quality Review Committee (MQRC). The MQRC is independent of the OHCQ and DDA and reviews the investigations of all deaths of participants that occur in DDA-licensed settings and services.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DDA and OLTSS are responsible for oversight of the incident reporting system.

On a quarterly basis, the DDA reviews and analyzes various information including:
1. The types of incidents;
2. Participant characteristics;
3. Type of providers; and
4. Timeliness of reporting and investigations.

This information is collected via the DDA incident reporting data system and tracking reports. The DDA also uses national experts, surveys, mortality reports, and research institutes to assist with its analysis, trending, and development of system improvement strategies.

The DDA's Regional Office Quality Enhancement (QE) Nurses review statewide and region-specific incidents related to health and safety, including all deaths. The DDA's QE Nursing Staff then recommends training or educational alerts to address any concerns or trends identified.

In some instances, the DDA's QE Nurse may do an on-site survey to review the provider's notes related to the provision of nursing services. The DDA's QE Nurse's review of incidents allows for trend identification and provider specific action that may lead to remediation. The DDA's QE Nurses provide ongoing technical and follow-up assistance to community nurses, providers, CCSs, participants, and their families.

The OLTSS has the authority to investigate or review any event or issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants. The OLTSS also uses its oversight of DDA's execution of delegated functions to ensure that the established procedures are being implemented as intended.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this

oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Use Of Alternative Methods To Avoid The Use Of Restraints

The DDA is committed to the use of positive behavioral interventions and supports for all participants. This includes an emphasis on the use of non-restrictive behavioral procedures and the reduction of restraints.

Positive behavior interventions are based on a tiered system that always begins with positive interactions before moving to formalized restrictive techniques.

1. Tier 1 includes providing positive interactions, choice making, and predictable and proactive settings or environments.

2. Tier 2 focuses on: (i) social, communication, emotional, and physiological intervention or therapies; (ii) mobile crisis teams; and (iii) behavioral respite based on trauma informed care.

3. Tier 3 is the use of restrictive techniques based on a functional assessment and approved strategies developed and approved in the Behavior Support Plan (BSP).

Method Of Detecting Unauthorized Use Of Restraints

The following strategies are used to detect unauthorized use of restraints:

1. The CCS provides each participant and their legal representative and family members with information about how to report incidents to the DDA. This information is also available on the DDA's website as a reference.

2. The CCS conducts quality monitoring and follow up activities on a quarterly basis, during which unauthorized restraints can be detected.

3. The DDA's regulations require all DDA providers to take appropriate and reasonable steps to ensure participants' health and safety including overseeing their staff. Providers conduct staff performance evaluations and monitoring activities to ensure each staff member is knowledgeable of applicable policies, person specific strategies, and reporting requirements.

As specified further in Appendix G-1, the PORII requires providers to report certain incidents, including unauthorized use of restraints to the DDA.

Anyone can call the DDA, OLTSS, or OHCQ to file a complaint, including the unauthorized use of restraints or seclusion on a participant. In addition, complaints can be filed anonymously via the OHCQ website.

Restraint Protocols

The DDA providers are required to comply with applicable regulations governing the development of BSP, provision of Behavioral Support Services (BSS), and use of restraints as per the Code of Maryland Regulations (COMAR) 10.22.10 which is further described in this section. The DDA's BSS are designed to assist participants, who exhibit challenging behaviors, in acquiring skills, gaining social acceptance, and becoming full participants in their community.

The emergency use of restraints is permitted in limited circumstances – when the participant presents a danger to the health or safety of themself or serious bodily harm to others. The use of seclusion is prohibited. DDA providers are required to document and report the use of emergency restraints in accordance with PORII.

DDA's regulations specify that DDA providers must ensure that a BSP is developed for each participant for whom it is required and must:

1. Represent the least restrictive, effective alternative or the lowest effective dose of a medication;

2. Be implemented only after other methods have been systematically tried, and objectively determined to be ineffective;

3. Be developed, in conjunction with the team, by qualified professionals who have training and experience in DDA's behavior support training curriculum;

4. Be based on and include:

a. A functional analysis or assessment of each challenging behavior as identified in the PCP;

b. Specify the behavioral objectives of the participant; and

c. A description of the hypothesized function of current behaviors, including their intended communication, frequency and severity and criteria for determining achievement of the objectives established;

5. Take into account the medical condition of the participant, describing the medical treatment techniques and when the techniques are to be used;

6. Take into account any trauma history of the participant to ensure that any behavioral objectives do not re traumatize the participant;

7. Specify the emergency procedures to be implemented for the participant with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others, including a description of the adaptive skills to be learned by the participant that serve as functional alternatives to the challenging behavior or behaviors to be decreased;

8. Identify the person or persons responsible for monitoring the Behavioral Support Plan;

9. Specify the data to be collected to assess progress towards meeting the participant's Behavioral Support Plan's objectives;

10. Ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented, as a part of data collection;

11. Detail a plan for use of positive supports and reduction of the restraint; and

12. Before implementation, the licensee shall ensure that each BSP, which includes the use of restrictive techniques:

a. Includes written informed consent of the: (i) participant; (ii) participant's legal guardian; or (iii) surrogate decision maker as defined in Title 5, Subtitle 6 of the Health-General Article of the Maryland Annotated Code;

b. Is approved by the PCP team; and

c. Is approved by the standing committee as specified in regulations.

Before a DDA provider discontinues a Behavioral Support Plan, the participant, their team, and a professional, appropriately licensed under Health Occupations Article with training and experience in applied behavior analysis, shall recommend that the participant no longer needs a Behavioral Support Plan. The provider shall discontinue a Behavioral Support Plan if the participant and their legally authorized representative (as applicable) revokes consent.

Practices To Ensure The Health And Safety Of Participants

As required by DDA’s regulations, the use of any restrictive technique must be described in an approved BSP. The licensed provider shall:

1. Ensure staff are trained on the specific restrictive techniques and strategies;

2. Collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the participant's challenging behavior;

3. Report unauthorized restraints;

4. Convene the team within 5 calendar days after an emergency use of a restrictive technique to review the situation and action taken;

5. Determine subsequent action, including whether the development or modification of a BSP is necessary; and

6. Document that applicable regulatory requirements have been met.

DDA providers shall ensure that their staff do not use:

1. Any method or technique prohibited by law, including aversive techniques;

2. Any method or technique that deprives a participant of any basic right specified in Title 7 of the Health-General Article of the Maryland Annotated Code or other applicable law, (e.g., access to a telephone; right to share room with a spouse; visitors; access to clothing and personal effects; vote; receive, hold, or dispose of personal property; and receive services), except as permitted in regulations;

3. Seclusion;

4. A room from which egress is prevented; or

5. A program which results in a nutritionally inadequate diet.

In addition, the DDA QE staff review use of restraints to identify remediation efforts or any preventive measures to reduce or eliminate restraint use. The DDA’s Director of Clinical Services will review unauthorized restraints or restrictive interventions on a quarterly basis. The DDA’s Director of Clinical Services will coordinate with the DDA’s Provider Services staff for any necessary provider specific remediation.

Required Documentation Of Use Of Restraints

DDA providers must document all use of restraints and restrictive techniques in the participant's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data are reviewed as part of monitoring of the BSP.

In addition, PORII requires that a provider report any unauthorized use of restraints.

Education And Training Requirements

In addition to training specific to a participant’s BSP, the DDA’s regulations require that all individuals providing behavioral supports and implementing a BSP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors, which is done through mandatory training of the DDA’s approved behavior support curriculum. In addition, family members will receive the necessary support and training to implement these positive behavior interventions as well.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DDA, OLTSS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

Methods of detecting unauthorized use, overuse, inappropriate or ineffective use of restraints and all applicable State requirements are followed.

1. The DDA and OHCQ monitor the DDA providers and ensure that services, including BSS, are delivered in accordance with the PCP and, if applicable, the BSP.

a. The OHCQ conducts regulatory site visits of DDA providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BSP.

b. DDA staff conduct on-site interviews with participants and the DDA provider's staff during visits and ascertain those services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with the services being received.

2. The OHCQ, DDA, and OLTSS conduct unannounced visits and observations of DDA providers, including interviewing participants, gauging the quality of services, identifying needs and concerns, and following up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.

3. The OLTSS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, the PCP, and BSP.

Data Use Strategies

1. The DDA and OHCQ meet on a quarterly basis to review data analysis and trends and discuss participant specific and systemic issues identified during their respective investigations and reviews of survey reports.

2. Data on BSS is analyzed and provided to the Statewide Behavioral Supports Committee (SBSC). The SBSC's mission is to promote and monitor the safe, effective, and appropriate use of behavior change techniques and provide recommendations to the DDA. The DDA uses recommendations from the SBSC and the Council on Quality and Leadership to make systemic improvements in the provision of Behavioral Support Services for participants receiving waiver services.

3. The DDA will also share data and trends with the DDA Waiver Advisory Council for input on system improvement strategies.

Method For Overseeing The Operation Of The Incident Management System And Frequency

The DDA uses quarterly and annual quality reports, based on performance measure data and system outcomes, to oversee and continuously assess the effectiveness of the incident management system.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive Interventions

The State defines restraints (restrictive interventions) as “Any physical, chemical or mechanical intervention used to impede an individual’s physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual’s BSP or those used on an emergency basis.”

Generally, as further detailed in Appendix G-2-a-i, DDA is committed to providing positive behavioral interventions and supports for all participants. This includes an emphasis upon the use of non-restrictive behavioral procedures and the reduction of physical restraints.

The DDA provides the same safeguards for use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-i.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DDA, OLTSS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

The DDA, OLTSS, and OHCQ perform the same oversight activities regarding the use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-ii.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

State's Method Of Detecting Unauthorized Use Of Seclusion

1. The DDA and OHCQ monitor DDA providers and ensure that services, including BSS are delivered in accordance with the PCP and, if applicable, the BSP.

a. The OHCQ conducts regulatory site visits of licensed providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BSP.

b. The DDA staff conduct on-site interviews with participants and the DDA provider's staff during visits and ascertain those services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with services being received;

2. The OHCQ, DDA, and OLTSS conduct unannounced visits and observations of DDA providers, including interviewing participants, to gauge quality of services, identify needs and concerns, and follow up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.

3. The OLTSS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, as indicated in the PCP and BSP.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

As per the Maryland Nursing Practice Act and applicable regulations, RN's are responsible for supervision and monitoring of participant medication regimens when delegation of medication and treatment to non-nursing staff is occurring. See Code of Maryland Regulations (COMAR) 10.27.11, governing delegation of nursing tasks.

State regulations require that the licensed health care practitioner must review any medication that has been prescribed to modify behavior at a minimum of every 90 days, that PRN orders for medications to modify behavior are prohibited, and that medications to modify behavior may not be used in quantities that interfere with an individual's ability to participate in daily living activities.

Activities of licensed health care practitioners, including RN's delegating nursing tasks, are overseen by Maryland’s Health Occupations licensing boards (e.g., Board of Physicians, MBON, etc.) to ensure these licensed health care practitioners practice within the scope of their licensure and in accordance with applicable laws and regulations.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

(a) Methods To Ensure Medications are Managed Appropriately

The OHCQ is involved in monitoring the community providers to ensure that medications are managed properly for participants. The OHCQ conducts regulatory site visits to licensed community providers to ensure that providers are providing services in accordance with State regulations.

The OHCQ staff review of the participant's medical charts, medication administration records, physician orders, nursing assessments and services, and staff medication administration training are part of licensing surveys.

The DDA's staff survey provider practices and provide technical assistance to develop and maintain effective systems (e.g. medication management) for serving individuals. As part of site visits, DDA staff review participant's records, including health records.

Upon OHCQ's or DDA's staff discovery of medication administration issues, the provider must develop a corrective action plan, which is monitored by the DDA staff.

Additionally, the reporting of medication errors is covered by the DDA's PORII. Under the policy, medication errors are classified as a "Type I" incident and defined as "the failure to administer medications as prescribed and/or the administration of medication not prescribed by a licensed physician/nurse practitioner/physician's assistant, e.g. incorrect dosage, time of administration and/or route, and omission of dosages."

OHCQ will:

1. Evaluate Incident Report to determine the need for investigation.

2. Refer incident to other agencies when appropriate.

3. Notify the DDA Regional Office if the incident is assigned for investigation.

4. Complete the investigation and, if necessary, issue a Statement of Deficiencies.

5. Request Plan of Correction (POC) if needed.

6. Review and approve the agency's POC.

7. Provide written report with findings and conclusions to involved parties.

The DDA will assist the Office of Health Care Quality investigation as requested.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDA Medication Technician Training Program (MTTP), establishes the tool to be utilized by the RN to determine an individual's ability to self-medicate. The MTTP also provides recommendations for monitoring by the RN. Code of Maryland Regulations 10.22.02.10A(8) requires that providers develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by the curriculum found in the MTTP. All DDA provider nurses and staff who administer medications must receive training following this curriculum.

All nurses must comply with the Maryland Nurse Practice Act, and applicable Maryland regulations, which gives RN's the ability to delegate the task of administering medication to appropriately trained and certified staff.

- **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Under the PORII, medication errors must be reported to OHCQ and the DDA.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors must be recorded.

(c) Specify the types of medication errors that providers must *report* to the state:

The following medication errors must be reported:

1) Any significant medication error that has the potential to cause harm;

2) Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physician's assistant, or nurse; and

3) Any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The responsibility of monitoring the performance of DDA providers in the administration of medication is shared by the OHCQ and the DDA. Each DDA Regional Office is staffed by a RN who provides training and technical assistance to nurses from DDA providers. In addition, the DDA QE Nurses review incidents related to medication errors. Both the OHCQ and the DDA conduct site visits of DDA providers to ensure their compliance with COMAR and the MBON regulations. The OHCQ, which investigates critical incidents including medication errors, provides investigative reports directly to the DDA and the providers. In addition, applicable reports from the DDA, the OHCQ and the OLTSS are reviewed during the quarterly quality meetings. Trends and untoward events indicated in incident report review are discussed between DDA QE Nurses and the provider community nurses as needed. Educational programming and alerts may be developed based on this information.

Problematic results from any of the above discovery processes may be addressed in several ways. These include but are not limited to:
1. A citation from the OHCQ set forth in a Statement of Deficiencies (SOD);
2. Requirements for further team planning which may necessitate a change to a participant's PCP;
3. Consultation with the individual's prescribing physician;
4. Required changes to a provider's policy or procedure; or
5. The imposition of deficiencies, requiring completion of a plan of correction (POC), and/or sanctions on a DDA provider.

On a systems level, the DDA uses data from surveys and critical incident reports to identify trends and develop new or revise policies, procedures, and training related to improved participant health.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW - PM 1: Number and percentage of critical incidents for which corrective actions were executed/planned on time. Numerator = Number of critical incidents for which corrective actions were executed/planned on time. Denominator = Number of critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Health & Welfare reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
QIO	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW - PM 2: Number and percentage of emergency room and admission hospitalization claims that had a matching critical incident reported. Numerator = Number of emergency room and admission hospitalization claims that had a matching critical incident reported. Denominator = total emergency room and admission hospitalization claims reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Health & Welfare reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW - PM3 - Number and percentage of critical incidents with investigation reviewed

per standards. Numerator = Number of critical incidents with investigation reviewed per standards. Denominator = total critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Health & Welfare reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Office of Health Care Quality, Quality Improvement Organization	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW - PM4 - Number and percentage of critical incidents with investigation completed on time. Numerator = Number of critical incidents with investigation completed on time. Denominator = total critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Health & Welfare reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

Office of Health Care Quality and Quality Improvement Organization		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW - PM 5 - Percentage of unauthorized restraint incidents where proper procedures were followed. Numerator = Number of unauthorized restraint incidents where proper procedures were followed. Denominator = total unauthorized restraint incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Improvement Organization Health & Welfare reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: 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.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW-PM6 % of participants who reported to have received preventive health screenings (PHCS) within the recommended timeframes (physical exam, routine dental exam, vision screening, hearing test, mammogram, pap test, colorectal cancer screening). N = # of participants. who reported to have received PHCS within the recommended timeframes. D = total participants surveyed who have a valid response.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Sampling Requirements

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Quality Improvement Organization (QIO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Incident Reporting and Investigations (Appendix G-1):

The DDA's QE staff provides oversight and ensures the DDA providers' compliance with applicable reporting requirements set forth in PORII. The DDA QE staff will provide technical assistance and support on an ongoing basis to the DDA providers and OHCQ to address specific remediation issues with the provider. Depending on the identified issues, the DDA may use a variety of remediation strategies including conference calls, letters, in-person meetings, and training.

Use of Unauthorized Restraints or Restrictive Interventions (Appendix G-2):

The DDA's Director of Clinical Services will review unauthorized restraints or restrictive interventions on a quarterly basis. The Director of Clinical Services will coordinate with the DDA Provider Services staff for any necessary provider specific remediation.

The DDA's Provider Services staff provide technical assistance and support on an on-going basis to the DDA providers and will address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference calls, letters, in-person meetings, and training.

Remediation with CCS Providers:

The DDA's Coordination of Community Services staff provide technical assistance and support on an on-going basis to licensed CCS providers and will address specific remediation issues with the provider. Depending on the identified issues, the DDA may use a variety of remediation strategies including additional communication with and training to providers. The DDA will document its remediation efforts in the provider's file.

Quality Improvement Organization (QIO)

The DDA contracts with a certified Quality Improvement Organization (QIO)-like Entity by the Centers for Medicare & Medicaid Services (CMS).

The DDA's designated Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.

Quality Improvement Organization requirements include:

1. Provide Health and Welfare reviews related to quality assurance of critical incident investigation and restraint related incident procedures. Ultimately, the purpose of the Health and Welfare process reviews are to verify that critical incidents are effectively investigated and resolved
according to waiver and state requirements, that restraint procedures are followed based on state requirements and that the health and welfare of participants in services is preserved and protected.

2. Conduct Utilization reviews to evaluate compliance with DDA standards related to:

a. Level of Care determinations;

b. Person Centered Planning;

c. Monitoring;

d. Billing and service documentation (review of paid claims for proper payment);

e. Provider staff qualifications; and

f. Provider licensing/certification process.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The MDH is the single state agency for Medicaid. The MDH's OLTSS is responsible for ensuring compliance with federal and state laws and regulations underpinning the operation of the Medicaid waiver program.

The MDH's DDA is the Operating State Agency (OSA) and funds community – based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four (4) Regional Offices (RO): Central, Eastern, Southern and Western. The MDH's OHCQ performs licensing surveys, and incident investigations. The DDA's designated Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.

The OLTSS, DDA or its designee, and OHCQ are responsible for tracking and trending data, as well as prioritizing, and implementing system improvements. To determine system improvements, the OLTSS, DDA or its designee, and OHCQ review: (1) operational data; (2) results from direct observation of service delivery; and (3) findings from participant, family, provider interviews and surveys. The analysis of discovery data and remediation efforts are conducted on an on-going basis via the Medicaid waiver performance measures. The OLTSS, DDA, Quality Improvement Organization, and OHCQ will review all data and information gathered with frequent periodicity to identify emerging trends and, when an emerging trend is identified, develop and implement a targeted system improvement.

The Medicaid waiver program's performance information is shared with the OLTSS and the DDA Waiver Advisory Council. The DDA Waiver Advisory Council is composed of various stakeholders, including Medicaid waiver program participants, family members, providers, advocacy organizations, and State representatives. The group recommends quality design changes and system improvement(s). Final recommendations are reviewed by the OLTSS and DDA for considered implementation.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: QIO	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The DDA and the OLTSS are the lead entities responsible for monitoring and analyzing the effectiveness of system design and any implemented changes.

A new DDA Waiver Advisory Council has been established with the purpose of creating meaningful engagement and a feedback loop with all interested stakeholders, and with a focus on people with lived experience. Participants will have the opportunity to advise in and provide recommendations to the DDA on system design, service delivery, and quality enhancement strategies for the DDA-operated Medicaid programs.

To analyze effectiveness, the DDA uses performance measure data and input from national experts, communities of practice, and survey tools. The DDA regularly consults with participants, their families, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the Council on Quality and Leadership, the University of Missouri Kansas City - Institute for Human Development (UMKC-IHD), and other experts to ensure that system design changes benefit participants and their families.

Since 2016, the DDA has been an active member of the National Community of Practice for Supporting Families (CoP-SF). Guided by the principles of Charting the LifeCourse (CtLC), this initiative aims to advance policy, practice, and systems transformation to better support individuals with intellectual and developmental disabilities and their families across the lifespan.

As part of this effort, DDA has integrated Charting the LifeCourse into its waiver programs, introduced new services, and improved numerous processes to enhance support for individuals and their families. Additionally, DDA established the Maryland Community of Practice for Supporting Families (MD CoP-SF), collaborating with community partners, including people and families, to drive change at state and local levels. This collective work empowers families to help their family members live fulfilling lives throughout all stages of life.

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 DDA is seeking to achieve Network Accreditation from the Council on Quality and Leadership. Achieving Network Accreditation uses baseline performance and seeks system transformation by enhancing outcomes people experience. Measurable progress is identified through data collection efforts using the Council on Quality and Leadership's Basic Assurances Reviews and Personal Outcome Measure Interviews.

The DDA has a contract with an entity that is certified by the CMS as a Quality Improvement Organization entity to:

1. Provide strategies that enhance the quality of life and help to ensure the health and wellbeing of individuals with intellectual and developmental disabilities;

2. Develop audit standards for the DDA’s services including review cases and analyze patterns of services related to assessed need and quality review;

3. Conduct ongoing utilization reviews to safeguard against unnecessary utilization of care and services and to assure efficiency, economy and quality of care;

4. Administer the DDA’s NCI; and

5. Support achievement of Network Accreditation from the Council on Quality and Leadership by conducting and collecting data for Basic Assurances Reviews and Personal Outcome Measures Interviews. Provide technical assistance with these reviews.

For specific system improvements, the DDA and its designees will monitor the antecedent data to ascertain whether the interventions have had the desired, positive impacts (based on ongoing review of the informing data). If systemic improvement efforts do not appear effective, the DDA and its designees will institute additional or

alternative approaches to effect positive and lasting changes.

The OLTSS monitors performance of this requirement by participating in the DDA Waiver Advisory Council and reviewing the DDA's quality reports on the effectiveness of system design and any implemented changes.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The DDA will evaluate QIS and results on an annual basis unless otherwise noted in the strategy description. The DDA shares information regarding its evaluation of the QIS in the annual quality report that is submitted to the OLTSS.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

NCI Survey and The Council on Quality and Leadership's Personal Outcome Measure Interviews

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

(a) Requirements concerning the independent audit of provider agencies

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

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

1. Single State Audit

There is an annual independent audit of Maryland's Medical Assistance Program ("Medicaid") that includes Medicaid's home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of providers' claims for payment for services. The contract for this audit is bid out every 5 years by Maryland's Comptroller's Office.

2. Office of Legislative Audits

The Maryland Office of Legislative Audits (OLA) conducts fiscal compliance audits every 3 years. The objectives of these audits are to examine financial transactions, records, and internal controls, and to evaluate the State agency's compliance with applicable State laws, rules, and regulations.

3. Office of the Inspector General Health (OIGH)

The Maryland Department of Health's Office of the Inspector General Health conducts audits of the DDA contractual and Waiver services. The objectives of these audits are:

a. Determine the amount of program revenue received and allowable expenditures incurred by the program for the DDA contracts;

b. Determine any amount due to the State or to the provider resulting from the operation of the program during the audit period:

c. Determine to the extent possible that relevant financial matters were conducted in accordance with the Department of Health's Human Services Agreement Manual (HSAM); and,

d. Provider recommendations for improving internal controls, ensuring fiscal compliance, or increased efficiency.

The Office of the Inspector General Health conducts the audits every 3 years. If there have been issues in the past, the Office of the Inspector General Health may audit more frequently.

4. Utilization Review

The DDA has hired a Quality Improvement Organization-like contractor to conduct post-payment utilization reviews of claims to ensure the integrity of payments made for all Medicaid waiver program services. These utilization reviews are to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for were provided to the participant. The reviews will consist of reviewing provider furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the participant's Person-Centered Plan Detailed Service Authorization (DSA) in LTSSMaryland. This review will apply to both Provider Managed (agency-directed) and Self-Directed Services Delivery Models.

The scope of the post-payment utilization review is limited to a statistically valid sample of claims by service category on an annual basis with a 95% +/-5% confidence interval. The number of providers audited will be based on the sample of participants selected for review. The review period will be 1 year of service.

The Contractor will conduct a remote audit of providers or Financial Management and Counseling Services agencies, requesting and reviewing information, including: staff notes and logs for the consumer(s) identified in the remote audit; the

provider's staffing plan, timesheets, training records, qualifications, payroll records and receipts; and any other documentation required by the Maryland Department of Health. The Contractor will prepare an initial findings report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the Person-Centered Plan.

Based on the results of the remote audit an on-site review might be required to look for systemic claims issues for the provider. The Contractor shall conduct the on-site review based on the presence of the following criteria:

a) Less services provided than billed;

b) Less or more services provided than authorized in Person-Centered Plan (+/- >14%);

c) Services provided did not match the definition of services billed or comply with applicable service requirements;

d) Staff qualifications could not be confirmed in the remote audit or the individual providing service was not appropriately qualified; and

e) Payments that cannot be substantiated by appropriate service record documentation.

No criterion is weighed more than any other. The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than 15 working days from the date of the conclusion of the audit. Based on the findings, the DDA will prioritize an on-site review based on the prevalence of audit issues.

For the on-site review, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's Person-Centered Plan. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the participant receiving services, and/or the participant's family or legal guardian and Coordinator of Community Services, as appropriate. The DDA may instruct the Contractor to expand the scope of their review based on system issues, such as abuse, and rights issues present in their reported findings.

The major difference between the remote reviews and the on-site reviews is that the on-site reviews require the Contractor to conduct an in-person review and interviews to determine if the service hours and supports match the level and quantity identified in the participant's Person-Centered Plan. The interview will include the participants receiving services, their family or legal guardian, and provider staff, as appropriate.

The Contractor shall prepare a summary of the review findings and will hold an exit interview in-person with the provider and provider staff as appropriate to verbally share a synopsis of their findings. This will be followed by a formal letter of findings and an opportunity for the provider to provide input.

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

The Contractor handles follow-up of corrective action plans, if any are required. The DDA Fiscal Unit will pursue any financial recovery owed to the State. If necessary, the DDA may also refer the matter to the Maryland Department of Health's Office of the Inspector General Health. The DDA is responsible for overseeing Contractor performance.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial

accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA - PM1: Number and Percentage of paid claims that are supported by documentation that services were delivered as outlined in the service plan. Numerator = number of claims reviewed that are supported by documentation. Denominator = number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
QIO Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA – PM2: Number and Percentage of paid claims for participants that were eligible on the date of service and met service authorization criteria. Numerator = number of paid claims reviewed for participants that were eligible on the date of service and met service authorization criteria. Denominator = number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
QIO Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***

☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA PM3: Number and Percentage of paid claims, paid in accordance with the reimbursement methodology. Numerator = number of reviewed claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
QIO Utilization Review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

PM1 – The Quality Improvement Organization will review a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

PM2 - The reimbursement logic built into the Medicaid Management Information System, Provider Consumer Information System2, and LTSSMaryland will ensure that Waiver program participants are eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, the DDA fiscal staff, or Medicaid. For Provider Consumer Information System2 claims, the DDA fiscal staff will monitor claims activity monthly to identify potential issues with the eligibility information or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into the Medicaid Management Information System, Provider Consumer Information System2, and LTSSMaryland will ensure that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, the DDA fiscal staff or Medicaid. For Provider Consumer Information System2 claims, the DDA fiscal staff will monitor claims activity monthly to identify potential issues with the reimbursement rate.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Performance Measure #1- Number and percentage of paid claims that are supported by documentation that services were

delivered as outlined in the service plan.

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

Performance Measure #2- Number and percentage of paid claims for participants that were eligible on the date of service and met service authorization criteria.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by the DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with Provider Consumer Information System2 or the LTSSMaryland Provider Billing Support staff and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, the DDA will adjust the claims accordingly and in a timely manner.

Performance Measure #3- Number and percentage of paid claims, paid in accordance with the reimbursement methodology.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by the DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with Provider Consumer Information System2 or the LTSSMaryland Provider Billing Support staff and/or Medicaid. Claims entered into the system incorrectly will be corrected and the universe of paid claims that were processed using the incorrect information will be identified. In the rare event that a claim is not coded or paid correctly, the DDA will adjust the claims accordingly and in a timely manner.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *QIO*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

The rate methodologies for Waiver Fee Payment System (FPS) services varied in WYs 1-2 as the DDA transitioned from a prospective payment system to a fee-for-service reimbursement model. Simultaneously the DDA transitioned from the current standalone platform, PCIS2, to the Medicaid Long Term Services and Supports system, or LTSSMaryland. The transition was completed in the first quarter of Waiver Year2.

In Waiver Years 1-2, Fee Payment System services, or those services whose claims were submitted using PCIS2, continued to use rates based on the rate methodology found on page 246 of the Community Pathways Waiver Application for 1915(c) Home and Community-Based Services Waiver: MD.0023.R06.01 - Jul 01, 2016 found here: https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%2 %20Effective%20July%201%202016.pdf.

PCIS2 rates used for: Community Development Services (formerly Community Learning Services), Community Living Group Home Services (formerly Residential Habilitation), Day Habilitation, Employment Discovery & Customization, Career Exploration, and Supported Employment services ended when billing for these services transitioned into LTSSMaryland at the end of Waiver Year 2. For Provider Consumer Information System2 non-Fee Payment System services, previous rates from the rate study completed November 2017 were revised and trended forward with a 9.5% Consumer Price Index adjustment and were used in Waiver Year 1-2.

The rate methodology for LTSSMaryland services are based on, The Brick Method ™, which is a structure used to develop standard fees for disability services that utilizes cost categories and studies their relationship to direct service support costs, or the wages of people performing the service. The foundation of the Brick is the direct support professional wage derived from the State Occupational Employment and Wage Estimate BLS data.

Included in the rates are 5 standard cost components that are assumed to be common to all social and medical services. They are Employment Related Expenses (ERE), Program Support (PS), Facility Costs (Day Habilitation only), Training, and Transportation. Additionally, fee schedule service rates include a 12% General & Administrative (G&A) cost component. A Rate Study Report was released on November 3, 2017 and is published on the DDA's website at https://dda.health.maryland.gov/Pages/Rate_Study_Report.aspx.

A geographically differentiated rate was proposed and adopted for rates in LTSSMaryland as a result of the DDA rate study conducted by JVGA. While the initial report released November 2017 did not recommend a differential, it was later concluded after further analysis that a differential was warranted to account for cost pressures and economic factors impacting certain areas within the State of Maryland.

JVGA recommended, and the DDA concurred, using the Bureau of Labor Statistics for the Washington, D.C. metro Metropolitan Statistical Area to establish a geographic differential rate for Waiver program services as the rates are based on independent wage data.

Payment of the Geographic Differential will be based on the person's residence in Frederick, Montgomery, Prince George's, Calvert, or Charles Counties and is applicable to all Waiver service rates in LTSSMaryland except Market Rate services, Behavioral Support Services, Medical Day Care, Environmental Assessment, Family Peer and Mentoring Supports, and Shared Living.

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

Fee schedule Service Rates (WYs 1-5)

Behavioral Support Services (BSS) - The rates for Behavioral Assessment, Plan and Consulting are based on the BLS hourly wage job code 19-3039 and the rate for Brief Support Implementation Services is based on the BLS hourly wage job code 19-4099. BSS Assessment, Plan, and Consultation service rates include ERE, Program Support, and G&A. The productivity assumption is 12 hours for the Assessment and the Plan. Brief Support Implementation includes ERE, Program Support, Training, and G&A.

Environmental Assessment -The rate is based on the BLS hourly wage job code 29-1122 with a productivity assumption of 6 hours and includes cost components ERE and G&A.

Family and Peer Mentoring - This service is based on a similar service provided in Arizona's Raising Special Kids program and applying Maryland cost values. To calculate the rate for Family and Peer Mentoring, JVGA recommended a wage level based on BLS job descriptions and wage levels for Maryland and used the program support percentage calculated for TCM. Since this was a new service without any history, JVGA based the percentage of employment related expenses and general and administrative costs on the Arizona Raising Special Kids services.

Housing Support Services - The rate is based on the hourly wage BLS job code 21-1012 and includes cost components ERE, Program Support, Training, and G&A.

Medical Day Care – The rate is established by the Medicaid program.

Nursing Support Services – The rate is based on hourly BLS wage data job code 29-1141 and includes ERE, Program Support, Training, and G&A.

Respite Care Services (Respite 15-minute unit and Daily) - The rates are based on the BLS wage job code 39-9021 and includes ERE, Program Support, Training, and G&A. The daily rate is based on the 15-minute unit rate with an assumption of 16 hours of services.

Fee Schedule Service Rates (applicable in LTSSMaryland)

Employment Services (Follow-Along Supports and On-going Job Supports) –The rates are based on BLS hourly wage job code 21-1012 and include ERE, Program Support, Training, and G&A. On-going Job Supports rate includes a Transportation cost component.

Employment Services (Discovery, Job Development and Customized Self-Employment Services) - The rates are based on hourly BLS wage job code 21-1012. Job Development includes cost components ERE, Program Support, Training, Transportation, G&A and a service adjustment to offset general job development activities. Customized Self-Employment includes ERE, Program Support, Training, and G&A. The self-employment plan assumes 8 hours of service.

Discovery includes Employee Related Expense, Program Support, Training, Transportation, and G&A. It is a service that assumes 10, 20, and 30 hours to complete each of the 3 milestones levels 1 to 3. Each discovery milestone must be completed as per DDA regulations and policy with evidence of completion of the required activities before the DDA or the FMCS approve them for payment.

Personal Supports- The rate is based on hourly BLS wage job code 21-1093 and includes ERE, Program Support, Training, Transportation, and G&A with a service adjustment for no shows and will be billed in 15-minute increments.

Personal Supports Enhanced Supports - The rate is based on BLS wage data job code 21-1093 and includes the cost components ERE, Program Support, Training, Transportation, and G&A with a service adjustment for no shows and will be billed in 15-minute increments. Personal Supports 2:1- The rate is twice the rate of Personal Supports Enhanced Supports.

Day Habilitation Services-. The rates for Day Habilitation 1:1 and 2:1 are based on the BLS wage data job code 21-1093 and include cost components ERE, Facility Program Support, Transportation, Training, and G&A. The rates for Day Habilitation Small and Large groups are based on the BLS wage data job code 21-1093 and include cost components ERE, Facility, Program Support, Transportation, Training, and G&A as well as a service adjustment.

Dedicated Supports Community Living Group Home 1:1 and 2:1, Dedicated Supports Community Living Enhanced Supports 1:1 and 2:1 and Dedicated Supports Supported Living 1:1 and 2:1 - The rates are based on BLS wage job code 21-1093 and include the cost components ERE, Program Support, Transportation, Training and G&A.

Community Development Services - The rates are based on hourly BLS wage job code 21-1093 and include ERE, Program Support, Training, Transportation, and G&A. The rate for Community Development Group includes a service adjustment. The rates assume staff to participant ratios: 1:1.5, 1:3, and 2:1.

Career Exploration - The rates are based on hourly BLS wage job code 21-1093 and include cost components ERE, Program Support, Training, Transportation, and G&A. The rate assumes staff to ratios of 1:6 for Large Group, 1:3 for

Small Group, and 1:3 for Facility.

Market Rate Services (WYs 1-5)

Assistive Technology and Services, Environmental Modifications, Employment Services Co-Worker Employment, Live-In Caregiver Supports, Remote Support Services, Respite Care Camp, Transition Services, Transportation and Vehicle Modifications, and beginning in Waiver Year 3, Assistive Technology Monthly Service Fees–

Payments for market rate services are based on the specific needs of the participant and the piece of equipment, item or service, type of modifications, or service design and delivery method as documented in the PCP DSA and PCIS2 as applicable. For needed services identified in the team planning process that do not lend themselves to an hourly rate (e.g., Assistive Technology, Environmental Modifications, etc.), the estimated actual cost, based on the identified need (e.g., a specific piece of equipment) or historical cost data, is included in the participant's PCP and service authorization budget. The applicable service definitions and limitations included in this Waiver program application may provide additional requirements for payment of these services. The DDA Regional Office fiscal staff review provider invoices to ensure costs for market rate services are authorized on an individual's PCP. The rate study established upper pay limits for these services, except for Assistive Technology. Assistive Technology includes various devices that are driven by market cost. Items that cost more than $2,500 must be recommended by an independent evaluation of the participants' needs. All requests are reviewed and approved by the DDA Regional Offices. The payment limit and any other limiting parameters will be programmed into the MMIS and LTSSMaryland to avoid overpayment of these services. Employment Services Co-Worker Employment rate is limited to an upper payment limit. The payment will only be made after DDA or FMCS determines with evidence that the required activities have been completed as per DDA regulations and policy.

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

Community Living Group Home Services - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components Employee Related Expense, Program Support Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-8) and whether overnight supervision is included.

Community Living Enhanced Supports - The rates are based on hourly Bureau of Labor Statistics wage job code 21-1093 and include cost components ERE, Program Support, Training, Transportation, and General & Administrative as well as a service adjustment. The rates are based on how many individuals reside in the home (1-4) and whether overnight supervision is included.

CONTINUED IN MAIN.B.OPTIONAL DUE TO SPACE LIMITATIONS

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

The flow of billings for Waiver program services is based on which service delivery model the participant is enrolled in: Provider Managed Services Model or SDS Delivery Model.

EVV Requirements

Personal Supports and Respite Care Services are required to be electronically recorded in the Department's EVV system or approved FMCS contractors' EVV solution. These requirements are related to 42 U.S.C. §1396b(l) and other State and federal laws, regulations, or guidance. The MDH provides an option to exempt EVV when the services are provided by a live-in caregiver. This applies to both the Provider Managed and SDS Delivery Model. The exemption is that live-in caregiver staff do not have to clock in and out in real time.

Billings under the Provider Managed Services Delivery Model

Until the billing for these services transitioned to LTSSMaryland and EVV for Personal Supports, Respite services and any other CMS required services using Maryland's In-Home Supports Assurance System (ISAS), Day Habilitation Services, Community Development Services, Employment Discovery & Customization, Community Living Group Home Service and Retainer Fees, Supported Employment, and Career Exploration claims were submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data collects information on: (1) the services included in the participant's PCP that can be billed; (2) the approved services and individualized budget set forth in PCIS2; and (3) the services rendered by the provider. PCIS2 authorized services are based on the PCP detailed service authorization. Services rendered are billed against the authorized services in PCIS2 to ensure that overbilling or billing for services not in the PCP does not occur.

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

Until the billing for these services transitioned to LTSSMaryland, Assistive Technology and Services, Behavioral Support Services, Environmental Assessments, Environmental Modifications, Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Housing Support Services, Live-In Caregiver Supports, Nursing Services, Participant Education, Training, and Advocacy Supports, Remote Support Services, daily and camp Respite Care Services, Shared Living Services, Supported Living Services, Transition Services, Transportation, and Vehicle Modifications were claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into the MMIS. The CMS 1500 was completed by the provider of services and submitted to the DDA for review. If the CMS 1500 was consistent with the participant's PCP, then the DDA submitted the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these service claims electronically to the MMIS. Claims that are rejected by the MMIS are reviewed by the DDA federal billing unit.

Based on this review, if the services were rendered in accordance with the PCP, the claim will be paid either with State funds only (if not a waiver-covered service), or the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

When DDA providers fully transition from billing in PCIS and using the manual paper billing process to billing in LTSSMaryland and using EVV for Personal Supports, Respite services and any other CMS required services, providers will electronically bill for all Waiver services for participants based on the services and allowable units in their LTSSMaryland PCPs DSA.

The provider submits Medical Day Care claims electronically for payment into the State's eMedicaid system which interfaces with the Medicaid Management Information System to generate federal claims based on allowable units in their plan. Claims that are rejected by the Medicaid Management Information System are reviewed by the provider. Based on this review, if the services were rendered in accordance with DDA's authorization, the claim is corrected and resubmitted. If the services were not actually rendered, then the claim is denied.

Billings under the SDS Delivery Model

For participants enrolled in the SDS Delivery Model (as described in Appendix E), only the FMCS provider can submit claims on behalf of participants self-directing their services. When processing claims on behalf of these participants, the FMCS provider compares employee timesheets or invoices against the participant's PCP and annual SDS budget, approved by the DDA. For claims that match, the FMCS provider then submits them to the MMIS. Claims that are rejected by the MMIS are reviewed by the FMCS. Based on this review, if the services were rendered in accordance with DDA's authorization, the claim will be paid either with State funds only (if not a waiver-covered service), or the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- (●) **No. state or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

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

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

MMIS edits are in place to validate the participants' waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid. While participant eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information system is updated on a regular basis. The information in the PCIS includes both the authorized service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP.

When billing and claims submission transitions into LTSSMaryland, the system will interface with the MMIS to determine participant eligibility before claims are sent. If a participant is determined not to be eligible on a date of service, the claim will not be submitted to Medicaid for payment until eligibility is updated. If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment.

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

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claim against the PCP DSA (under the Provider Managed Services Delivery Model), PCIS2 authorization (as applicable) and the FMCS verifies the claim against the DDA-approved annual SDS budget (under the SDS Delivery Model). Please refer to Appendix I-2, subsection b. above for further details about these processes.

When billing for services transitioned into LTSSMaryland, providers will only be able to bill for services and units that have been approved and included in the PCPs DSA.

c) Verification of Service Provision

The participant's CCS performs quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the PCP for participants enrolled in the Provider Managed Services or the DDA-approved annual SDS budget for participants enrolled in the SDS Delivery Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by the DDA (see Appendix I-1).

If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment. The DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1. Additionally, EVV was implemented along with LTSSMaryland to verify service provision of Personal Support services, Respite and any other CMS required services.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For participants enrolled in the SDS Delivery Model (as described in Appendix E), Waiver program services are paid by the FMCS provider and then the FMCS submit the claim through the the MMIS. Providers are informed of the billing process during orientation and training.

The DDA provides oversight of the FMCS providers. The utilization review contractor will conduct reviews. The reviews also monitor and assess the performance of the FMCS provider including ensuring the integrity of the financial transactions that they perform.

The utilization review contractor will conduct a remote review of the FMCS provider, requesting and reviewing information, including: staff notes and logs for the participants identified in the remote review; training records, the staffing qualifications, timesheets, payroll records and receipts; and any other documentation required by the MDH.

For the utilization review, the scope of the post-payment review is limited to a statistically valid sample of participants and claims by service with a 95% +/-5% confidence interval. The review period will be one year of services.

In addition to the utilization review by the independent contractor, the Department's current contract for the FMCS providers includes various requirements that will be overseen by the MDH FMCS Program Manager. This includes a variety of monthly reports such as Employee Training Reports, Payroll Reports Error Reports, Participant Report, and Monthly and Historical Reports. In addition, the contractors will conduct satisfaction surveys and report the results of the surveys to the contract monitor on a quarterly basis.

The FMCS provider will be required to submit an annual audit by an independent Certified Public Accountant (CPA) or an independent CPA firm to verify the activities required by the scope of work.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Some local Health Departments provide Respite Care services due to a lack of qualified providers in their area to meet the needs of the participants receiving these services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

In Waiver Years 1-2 for Provider Consumer Information System2 services, the payment methodology, outlined in COMAR, 10.22.17.10-.13, reassignment may be made to the DDA. Conditions for participation from COMAR 10.09.26.03 require DDA providers to have a provider agreement in effect with the DDA and the Medical Assistance Program.

DDA providers elect to become licensed or approved providers and acknowledge the voluntary reassignment of payments. The DDA has one payment methodology for fee payment services (Residential, Day, Supported Employment, and Personal Supports). Providers agree to accept payments through this methodology.

The DDA provider agreements acknowledge the reassignment of Medicaid payments to the DDA as under the current payment methodology the DDA prospectively pays the providers for expected expenditures for services and the reassignment permits the DDA to recover the outlay for the expenditures. At the end of the first quarter of Waiver Year2, this payment methodology ended when providers began to bill using LTSSMaryland, as they will be paid directly for their services.

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

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) A potential provider interested in becoming an OHCDS provider may apply to do so as part of initial licensure, or by amending their current license, and must meet all regulatory requirements outlined in Code of Maryland Regulations (COMAR) 10.22.20.05. A provider may be designated an OHCDS if they submit a DDA application to become an OHCDS provider, and they are a licensed DDA provider for a DDA Fee Payment System service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly.

Community agencies and DDA-licensed or certified providers can apply to be an Organized Health Care Delivery System provider. The following services can be provided by an Organized Health Care Delivery System provider:
1. Assistive Technology and Services;
2. Environmental Assessments and Environmental Modifications;
3. Family Caregiver Training and Empowerment Service;
4. Live-in Caregiver Supports;
5. Participant Education, Training and Advocacy Supports;
6. Remote Support Services;
7. Respite Care Services;
8. Transition Services;
9. Transportation Services; and
10. Vehicle Modifications.

b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website.

c) The CCS supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an OHCDS, or other qualified providers under the SDS Delivery Model. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time.

d) An OHCDS must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. OHCDS providers shall enter into a subcontract with each provider as per DDA policy. Subcontracts may include the scope, frequency, duration, and cost of services to be provided; documents the qualifications of the provider of service; details service termination procedures; is consistent with the participant's PCP and is executed by all parties to the contract. The OHCDS is required to maintain a detailed record on the purchase of services from qualified entities or individuals, including invoices.

e) In the OHCDS application, the provider agrees to submit an aggregate annual summary, delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individuals serviced by each subcontractor. The report will be due within 60 days of the end of the State fiscal year. As part of the DDA's quality assurance procedures, the QIO surveys OHCDS providers for their compliance with regulatory requirements, including those requirements governing contracts with qualified providers.

f) For services not billed in LTSSMaryland, billing for OHCDS provider contract services is completed by submitting an invoice and CMS 1500 Forms or by direct provider electronic submission in the MMIS system. In LTSSMaryland, bills will be submitted for the cost of the services based on what is authorized in a person's PCP. The DDA and Medicaid reviews all claims submitted. The DDA will monitor and conduct oversight of the OHCDS by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

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

☐ ***Other State Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

○ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

The Maryland Annotated Code, Health-General, §7-705 states that the DDA will use local funds to offset the State's share of support of Day Habilitation and vocational services. The amount of local funds is limited to the amount paid by each jurisdiction in FY 1984. These funds meet the applicable federal requirements.

Each state fiscal year, the DDA invoices all 23 counties and Baltimore City for the amount noted in statute. The jurisdictions pay the state by check or through an interagency transfer. These local funds are credited to the appropriate budget and are applied to the appropriate expenditures.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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

or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

- ☐ ***Health care-related taxes or fees***
- ☐ ***Provider-related donations***
- ☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

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

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

The cost of room and board from service costs in determining payment rates for Community Living-Group Home and Community Living-Enhanced Supports are excluded. The Medicaid payment does not include either of the following items which the provider is expected to collect from the participant: (1) Room and board; or (2) Any assessed amount of contribution by the participant for the cost of care.

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

Appendix I: Financial Accountability

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

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

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

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method

used to reimburse these costs:

Live-In Caregiver Supports is an OHCDS service and the reimbursement method for these services are outlined in section Item I-3-g-ii.

Live-in Caregiver Supports is limited to the cost of rent and cost of food associated with the live-in caregiver (and not the participant), calculated as follows:

1. The cost of rent, associated with the live-in caregiver, must be calculated as follows:

a. The difference in cost between: (i) a unit sufficient to house the participant only; and (ii) a unit sufficient to house the participant and the live-in caregiver, providing separate bedrooms for each; and

b. The cost must be based on, and not exceed, the Fair Market Rent for the jurisdiction in which the unit is located as determined by the Department of Housing and Urban Development.

2. The cost of food, associated with the live-in caregiver, must be calculated as follows:

a. The cost of food attributable solely to the live-in caregiver; and

b. The cost must be based on, and not exceed, the U.S. Department of Agriculture's Monthly Food Plan Cost at the 2-person moderate plan level.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

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

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	127520.16	14627.48	142147.64	304278.06	6572.50	310850.56	168702.92
2	143151.49	15139.44	158290.93	314927.79	6802.54	321730.33	163439.40
3	164576.98	17468.43	182045.41	207842.29	9016.74	216859.03	34813.62
4	169535.04	17992.49	187527.53	214077.56	9287.24	223364.80	35837.27
5	174588.30	18532.26	193120.56	220499.89	9565.86	230065.75	36945.19

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	16365	16365
Year 2	16498	16498
Year 3	20573	20573
Year 4	20710	20710
Year 5	21446	21446

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay for waiver years 1-2 is 353 days. This is based on the average length of stay reported on the Center for Medicare and Medicaid Services 372(S) for the Community Pathways Waiver for fiscal years (FY) 2018-2019. The average length of stay for waiver years 3-5 was updated to 358 days based on the average length of stay reported on the Fiscal Year 2022 – 2023 Center for Medicare and Medicaid Services (CMS) 372(S) for the Community Pathways Waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimated number of users for Factor D estimates for WYs 1-2 are based on analysis of CMS - 372 reports and user enrollment in CPW services in FY22 - FY23 LTSSMaryland PCP data and FY 22 participants self-directed service enrollment data. The FY22 - FY23 LTSSMaryland data file includes services on approved service plans for participants receiving services in the PCIS2 and LTSSMaryland and for those who are self-directing their services. The FY22 Self-Directed service data file includes service user data only for participants self-directing their services. The estimated number of users for each service is based on the average of FY19 - FY20 CPW CMS 372(s) report utilization or calculated using the basis of the percentage of users in each service to the total users in the CPW program using data from the FY22 - FY23 LTSSMaryland person-centered plan data file and the FY22 Self-Directed services data file for self-directed services.

The percentages are as follows: Assistive Technology and Services – .5%; Behavioral Assessment and Behavioral Plan – 2.23%; Behavioral Consultation – 13.7%, Brief Support Implementation – 8.7%; Dedicated Hours for Supported Living 1:1 – 1.25%; Dedicated Hours for Supported Living 2:1 - .07%; Environmental Assessment - .04%; Environmental Modifications - .08%; Family Caregiver Training and Empowerment Services - .3%; Individual and Family Directed Goods and Services – 8.87% of estimated self-directed services users only; Individual and Family Directed Goods and Services Staff Recruitment and Advertising – 20% of estimated self-directed services users only; Live-In Caregiver Supports - .04%; Nursing Support Services – 7%; Participant Education, Training, and Advocacy Supports - .3%; Personal Supports – 31.63%; Personal Supports Enhanced Support – 4.92%; Remote Support Services - .03%; Respite Care Services Day – 3.31%; Respite Care Services Camp – 2.7%; Support Broker – 78.26% of estimated self-directed services users only; Supported Living – 2.59%; Transition Services - .35%; Transportation – 8.88%; and Vehicle Modifications - .03%.

As providers continued to transition their service billing from the PCIS2 system to LTSSMaryland, we estimated users of PCIS2 services in WYs 1-2 with all services estimated to be billed in LTSSMaryland in WYs 3-5. Some of the same services in both systems are billed using different units of service, so estimated users were included for both PCIS2 and LTSSMaryland services. PCIS2 hour unit services, Family Peer and Mentoring Supports, Housing Support Services, and Respite Hourly are 15-minute unit services in LTSSMaryland and PCIS2. Day unit services, Community Development Services, Day Habilitation, and Career Exploration services are 15-minute unit services in LTSSMaryland.

We estimated about half of the users remaining in PCIS2 services, from a FY22 PCIS2 service data file, to transition to billing the LTSSMaryland service in WY1 with most of the remaining users transitioning in WY2 and all remaining users having transitioned by WY3. Provider billing was fully transitioned from PCIS2 to LTSSMaryland in the first quarter of WY 2. The estimated number of users for each of these services was based on the average of FY19 - FY20 CPW CMS - 372(S) report utilization for the services or calculated using the basis of the percentage of users in each service to the total users in the CPW program using data from the FY22 - FY23 LTSSMaryland person-centered plan data file, and then applying the percentages to the Total Estimated Unduplicated Participants in Appendix B for each WY to get the estimated number of users for each service. For WYs 1-2, the estimated remaining PCIS2 service users are deducted from the estimated users for each LTSSMaryland service.

The percentages are as follows: Community Development Services (CDS) 1:1 – 13.8%, Community Development Services 2:1- .6%; Community Development Services Small Group – 18.6%; Community Living Enhanced Supports - .74%; Community Living Enhanced Supports Retainer Fee- 45% of estimated Community Living Enhanced Support users; Community Living Enhanced Supports Trial Experience - .01%; Community Living Group Home – 41.31%; Community Living Group Home Retainer Fee- 45% of estimated Community Living Group Home users; Community Living Group Home Trial Experience - .01%; Day Habilitation 1:1 – 12.95%; Day Hab. 2:1 - .37%; Day Hab. Small Group – 20.35%; Day Hab. Large Group – 20.35%; Dedicated Hours Community Living Enhanced Supports 1:1- .45%; Dedicated Hours Community Living Enhanced Supports 2:1- .08%; Dedicated Hours for Community Living Group Home 1:1- 25.25%; Dedicated Hours for Community Living Group Home 2:1 – 1.25%; Employment Services- Discovery 1, Discovery 2, and Discovery 3 – 1.59%; Follow Along Supports – 13.8%; Job Development – 7.93%; On-going Job Supports – 13.4%; Co-Worker Employment Supports - .01%; Customized Self-Employment Services - .03%.; Family and Peer Mentoring Supports - .2%; Housing Support Services - .6%; Respite Services – 9%; Shared Living Level 1 - .26%; Shared Living Level 2 - .93%; Shared Living Level 3 - .32%; Career Exploration Facility - .82%, Large Group - .33%; and Small Group – 2.27%.

The users for PCIS2 services Supported Employment and Employment Discovery and Customization were estimated to transition to Employment Services in LTSSMaryland in WYs 1-2 based on the remaining users in the FY22 PCIS2 service data file. No users are estimated for these services in WYs 3-5.

The users for Medical Day Care were estimated at 5.5% of estimated unduplicated participants for WYs 1-2 based on the average of FY19 - FY20 CPW CMS-372(S) report utilization and are estimated at 3.2% of estimated unduplicated participants for WYs 3-5 based on the average of FY22 - FY23 CPW CMS-372(S) report utilization.

In WY 3, DDA will merge participants from three approved Waiver programs into one Waiver program. Participants enrolled in the CSW and FSW will be combined with participants in the CPW, therefore the estimated number of users for Factor D estimates for WYs 3-5 have been updated. The State has elected to use FY25 - 26 LTSSMaryland PCP data and FY24 - 25 actual paid claims data to project Factor D estimates instead of the CMS 372(S) report as the report does not reflect the merged Waiver programs and the completed billing system transition. The state's claims and budget data capture the recent changes to the Waiver program and thus serve as a more accurate resource to base the state's estimates. The estimated number of users for all services except Assistive Technology Monthly Service Fee and Day-to-Day Administrative Support, are calculated based on the percentage of users enrolled in traditional and self-directed services in all three Waiver programs to the total number of Waiver users. Assuming the trend remains the same for WYs 3 - 5, these percentages are then applied to the Total Estimated Unduplicated Participants in Appendix B to get the estimated number of users for each service.

The percentages are as follows: Assistive Technology and Services – 1.4%; Behavioral Assessment and Behavioral Plan – 3.2%; Behavioral Consultation – 20.1%, Brief Support Implementation – 12%; Career Exploration Facility - .32%, Large Group - .06%; and Small Group – .9%; Community Development Services (CDS) 1:1 – 19.7%, Community Development Services 2:1- 1.3%; Community Development Services Small Group – 29.6%; Community Living Enhanced Supports - .3%; Community Living Enhanced Supports Retainer Fee- 30% of estimated Community Living Enhanced Support users; Community Living Enhanced Supports Trial Experience - .02%; Community Living Group Home – 35%; Community Living Group Home Retainer Fee- 33% of estimated Community Living Group Home users; Community Living Group Home Trial Experience - .02%; Day Habilitation 1:1 – 9%; Day Hab. 2:1 - .3%; Day Hab. Small Group – 20.7%; Day Hab. Large Group – 8.9%; Dedicated Hours Community Living Enhanced Supports 1:1- .27%; Dedicated Hours Community Living Enhanced Supports 2:1- .03%; Dedicated Hours for Community Living Group Home 1:1- 19.23%; Dedicated Hours for Community Living Group Home 2:1 – 1.25%; Dedicated Hours for Supported Living 1:1 – .8%; Dedicated Hours for Supported Living 2:1 - .06%; Employment Services- Discovery 1, Discovery 2, and Discovery 3 – 1%; Follow Along Supports – 12.4%; Job Development – 5.6%; On-going Job Supports – 9.3%; Co-Worker Employment Supports - .02%; Customized Self-Employment Services - .02%. Environmental Assessment - .7%; Environmental Modifications - .4%; Family and Peer Mentoring Supports - .2%; Family Caregiver Training and Empowerment Services - .04%; Housing Support Services – 2.8%; Individual and Family Directed Goods and Services – 6.9%; Individual and Family Directed Goods and Services Staff Recruitment and Advertising – 1.1%; Live-In Caregiver Supports - .04%; Nursing Support Services – 6.6%; Participant Education, Training, and Advocacy Supports - .02%; Personal Supports – 35%; Personal Supports Enhanced Support – 4.7%; Personal Supports 2:1- .14%; Remote Support Services - .04%; Respite Care Services Day – .6%; Respite Services – 9.73%; Respite Care Services Camp – 1.2%; Shared Living Level 1 - .1%; Shared Living Level 2 - .6%; Shared Living Level 3 - .22%; Support Broker – 16.8%; Supported Living – 2.65%; Transition Services - .06%; Transportation – 8.4%; and Vehicle Modifications - .08%.

In Waiver Year 3, the Assistive Technology Monthly Service Fee and Day-to-Day Administrative Support are included in the Waiver. Due to a lack of prior utilization data, the estimated number of users for these services in Waiver Years 3-5 was determined as follows: for the Assistive Technology Monthly Services Fee, 5% of the estimated users of Assistive Technology services, and for the Day-to-Day Administrator, 75% of the estimated users self-directing their services which is based on Support Broker service utilization.

The Average Units per User for WYs 1-2 are based on historical utilization of services in the CPW CMS 372(S) report data FY18 - 20 and FY21 average actual utilization of CPW services billed in PCIS2, or allowable unit limits set in the Waiver for all services except: Employment Services Job Development and On-going Job Supports that were estimated by calculating the average units per user of CPW participants enrolled in these services in the FY22 - FY23 LTSSMaryland budget data file, for Personal Supports, Personal Supports Enhanced,

Supported Living, Dedicated Hours for Supported Living 1:1, and Dedicated Hours for Supported Living for 2:1 that were estimated using actual FY22 LTSSMaryland service expenditures. Additionally, average units per user for WYs 1-2 for Dedicated Hours for Community Living Enhanced Support and Community Living Group Home were estimated based on budgets in the FY22 - 23 LTSSMaryland budget data file.

****CONTINUED BELOW DUE TO SPACE LIMITATIONS****

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

****CONTINUED FROM ABOVE DUE TO SPACE LIMITATIONS****

In WYs 1-2, the estimated units per user for Community Development Services, Day Habilitation, and Career Exploration Services in LTSSMaryland reflect the unit change from a Day to a 15-minute unit and the removal of the limitation of receiving only one Day service per day. For these services, the units per user estimates are based on an average of three hours a day, which was calculated by dividing the budget amounts by users and the rate in the FY22 - FY23 LTSSMaryland budget file. The three-hour average multiplied by the average actual Days billed in FY21 in PCIS2 are the estimated units per user for these services.

In WYs, 3-5, the estimated average units per user are based on actual service utilization of Waiver services from FY24 - FY25 paid claims data or allowable unit limits set in the Waiver for all services except Medical Day Care where the average units per user are based on the average units from the FY22-23 CPW CMS 372(S) reports. The state's claims data captures the recent changes to the Waiver program and thus serves as a more accurate resource to base the state's estimates. In Waiver Years 3-5, Support Broker services units are updated to reflect a unit change from an Item to a 15-minute unit.

For Waiver Years 3-5, the billing units for Live-in Caregiver Supports and Co-Worker Employment Supports were changed from "Monthly" to "Item." This adjustment was made because these are market-rate services, and the LTSSMaryland system is unable to process monthly market-rate billing. By changing the unit to "Item," these services can now be billed at market rates within the LTSSMaryland system. The Behavioral Consultation 15 minute unit, although approved in the 2023 Waiver Renewal, was not initially reflected in the portal. The public comment documents for the Waiver Renewal, however, correctly listed the 15-minute units. This unit was subsequently updated in the portal with the submission of the latest amendment. There is no need to update service estimates for these services for Waiver Years 3-5 as they were based on actual service utilization.

The Average Cost per Unit for WYs 1-2 for LTSSMaryland rate-based services is based on the Department's approved FY23 LTSSMaryland standard rates found on DDA's website here: https://health.maryland.gov/dda/Pages/rates.aspx#ffs and trended forward using the average inflation rate of 3.5 percent from the 2019 - 2021 Bureau of Labor Statistics (BLS) Consumer Price Index for All Urban Consumers (CPI-U) for Medical Care for the Washington – Baltimore region. See Appendix I for detailed rate methodologies for each service and a detailed rate file is available upon request. The LTSSMaryland rate-based services include: all Behavioral Support Services, all Community Development Services (15-minute unit), all Community Living Enhanced Supports services; all Community Living Group Home services, all Dedicated Hours services, all Day Habilitation Services (15-minute unit), Employment Services Discovery 1,2, and 3, Follow Along Supports, Job Development, On-going Job Supports, and Customized Self-Employment, Family and Peer Mentoring Supports (15-minute unit), Housing Support Services (15-minute unit), Nursing Support Services, Personal Support services, Respite Care Services Day and Respite, all levels of Shared Living, Supported Living, and all Career Exploration services (15-minute unit). In WY 3, the average cost per unit was estimated for each service using FY24 - 25 paid claims data and FY24 - 25 LTSSMaryland budget files and adding a proposed 1% cost of living increase then trending the estimates forward in WYs 4-5 using the average inflation rate of medical care from December 2023-2024 BLS CPI-U in the Baltimore - Columbia - Towson, Maryland region of 3.1 percent rounded to 3 percent. The state's claims data captures the recent changes to the Waiver program and thus serves as a more accurate resource to base the state's estimates.

Additionally, a geographically differentiated rate, or premium rate, was adopted for rates in LTSSMaryland as of January 19, 2021. Payment of the premium rate will be based on the person's residence in Frederick, Montgomery, Prince George's, Calvert, or Charles Counties and is applicable to all Waiver service rates in LTSSMaryland, except Market Rate services, Medical Day Care, all Behavioral Support Services, Environmental Assessment, Shared Living 1, 2, and 3, and Family Peer and Mentoring Supports. The average cost per unit for services was based on standard rates only for WYs 1-2 in absence of historical utilization information in the CMS-372(S) report. In WY 3, for the rate-based services without a premium rate, the average cost per unit was estimated as the Department's approved FY25 LTSSMaryland standard rates found on DDA's website here: https://health.maryland.gov/dda/Pages/rates.aspx#ffs rate plus a proposed 1% cost of living increase then trending the estimates forward in WYs 4-5 using the average inflation rate of medical care from December 2023-2024 BLS CPI-U in the Baltimore-Columbia-Towson, MD region of 3.1 percent rounded to 3 percent.

The Average Cost per Unit for WYs 1-2 for PCIS2 Fee-Payment System (FPS) services are based on averages

from the CPW CMS 372(S) FY18-20 and/or FY21 average costs for actual billed services in PCIS2 trended forward using the approved American Rescue Plan Act (ARPA) rate increase of 5.5 percent in FY22 and the approved Cost of Living adjustment of 8% in FY23, and then trending forward in WYs 1-5 using the average inflation rate of 3.5 percent from the 2019-2021 BLS CPI-U for Medical Care for the Washington – Baltimore region. The PCIS2 FPS services include Day unit services Community Development Services, Community Living Group Home services, Day Habilitation, Career Exploration, Employment Discovery and Customization, Shared Living, and Supported Employment.

The average Cost per Units per WY for PCIS2 non-FPS services in WYs 1-2 are based on rates from the previous rate study done by Johnston, Villegas-Grubbs and Associates, LLC in 2017 and then subsequently reviewed and validated by another vendor, Optumas. These rates were adopted for services authorized in PCIS2 including, all Behavioral Support Services, Family and Peer Mentoring Supports (Hour), Housing Support Services (Hour), and Respite Care Services Hour, Environmental Assessment and Nursing Support Services. These rates were trended forward by approved FY cost of living increases as well as the American Rescue Plan Act (ARPA) rate increase and for WYs 1-2 using the average inflation rate of 3.5 percent from the 2019-2021 BLS CPI-U for Medical Care for the Washington – Baltimore region.

For Assistive Technology and Services, Environmental Modifications, Family Caregiver Training and Empowerment Services, Individual and Family Directed Goods and Services, Live-In Caregiver Supports, Participant Education, Training, and Advocacy Supports, Respite Camp, Support Broker, Transition services, Transportation and Vehicle Modifications services, the average cost per unit per WYs 1-2 based on averages from the CPW CMS 372(S) report FYS 18-20. In WYs 3-5, the average cost per unit is based on the average cost per user from FY24-25 paid claims data. The state's claims data captures the recent changes to the Waiver program and thus serves as a more accurate resource to base the state's estimates. For Waiver Years 3-5, the average cost per unit for Assistive Technology Monthly Service Fees is determined by market research, as there is no historical cost data available and Day-to-Day Administrative Support average cost per unit is based on Fiscal Year 24-25 paid claims data for Support Brokers

In WYs 1-2, the average cost per unit for Employment Services Co-Worker and Remote Support Services were based on the average budgets in the FY22 - FY23 LTSSMaryland budget data file in absence of historical data in the CPW CMS-372(S). In WYs 3-5, the average cost per unit was based on the average cost per user from FY24-25 paid claims data.

In WYs 1-2, The the average cost per unit per WY for Medical Day Care was based on the approved rate for FY23 (WY1) and trended forward in WYs 2-5 using the average inflation rate of 3.5 percent from the 2019-2021 BLS CPI-U for Medical Care for the Washington – Baltimore region. In WY 3, the average cost per unit was updated to the actual FY25 rate plus a proposed 1% cost of living increase then trended forward in WYs 4-5 using the average inflation rate of medical care from December 2023-2024 BLS CPI-U in the Baltimore-Columbia-Towson, MD region of 3.1 percent rounded to 3 percent.

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****Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' was calculated for WYs 1-2 based on the actual amount in the FY2020 CMS-372(S) report for the CPW and trended forward using the average inflation rate of 3.5 percent from the 2019-2021 BLS CPI-U for Medical Care for Washington-Baltimore. For WY 3, Factor D' was based on the actual amount in the FY2023 CPW CMS-372(S) report and trended forward using the average inflation rate of medical care from December 2023-2024 BLS CPI-U in the Baltimore-Columbia-Towson, MD region of 3.1 percent rounded to 3 percent. This data removes the cost of prescribed drugs under the provisions of part D.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimated annual average institutional costs that would be incurred for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver Center for Medicare and Medicaid Services 372(S) Fiscal Year 2020 report. The 3.5 percent inflation rate applied to Factor G for Waiver Years 1-2 is based on 2019-2021 Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) for Medical Care for Washington – Baltimore. For waiver year 3, Factor G was updated using more recent data analyzed by the Hilltop Institute. Using MMIS2 claims data, Hilltop identified Intermediate Care Facilities for Individuals with Intellectual Disabilities providers and pulled unduplicated residents, total days of care, average length of stay (ALOS), and total Medicaid institutional expenditures with the stay span. Hilltop analyzed the institutional costs using several methods and DDA opted to base Factor G on the Fiscal Year24 annualized average institutional costs based on MMIS per member per day rate multiplied by the 358 average length of stay for the Community Pathways Waiver and trended forward in waiver years 4-5 using the average inflation rate of medical care from December 2023-2024 Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) in the Baltimore-Columbia-Towson, MD region of 3.1 percent rounded to 3 percent.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimated annual average per capita Medicaid costs for all other services other than those included in factor G for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver Center for Medicare and Medicaid Services 372(S) Fiscal Year2020 report. The 3.5 percent inflation rate applied to Factor G' for Waiver Years 1-2 is based on 2019 - 2021 Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) for Medical Care for Washington – Baltimore. For waiver year 3, Factor G' was updated using more recent data analyzed by Hilltop Institute. Using participants identified for Factor G with an Intermediate Care Facilities for Individuals with Intellectual Disabilities stay, Hilltop pulled total Medicaid non-institutional expenditures within the Intermediate Care Facilities for Individuals with Intellectual Disabilities stay for the cohort. Hilltop annualized the average Medicaid non-Intermediate Care Facilities for Individuals with Intellectual Disabilities costs incurred during an Intermediate Care Facilities for Individuals with Intellectual Disabilities stay by multiplying the cost per member per day by 365 days. DDA used the Fiscal Year 24 cost per member per day and annualized the costs based on the 358 average length of stay for the Community Pathways Waiver and trended forward in waiver years 4-5 using the average inflation rate of medical care from December 2023-2024 Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) in the Baltimore-Columbia-Towson, Maryland region of 3.1 percent rounded to 3 percent.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Career Exploration	
Community Living - Group Home	
Day Habilitation	
Live-in Caregiver Supports	
Medical Day Care	
Personal Supports	
Respite Care Services	
Supported Employment (phased out effective years 3, 4, and 5)	
Assistive Technology and Services	
Behavioral Support Services	
Community Development Services	
Community Living - Enhanced Supports	

Waiver Services	
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	
Employment Services	
Environmental Assessment	
Environmental Modifications	
Family and Peer Mentoring Supports	
Family Caregiver Training and Empowerment Services	
Housing Support Services	
Individual and Family Directed Goods and Services	
Nursing Support Services	
Participant Education, Training, and Advocacy Supports	
Remote Support Services	
Shared Living	
Support Broker Services	
Supported Living	
Transition Services	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						2305906.24
LTSS Large Group	15 minutes	48	1056.00	2.57	130268.16	
LTSS Small Group	15 Minutes	349	1056.00	3.42	1260420.48	
LTSS Facility	15 Minutes	114	1056.00	3.81	458663.04	
PCIS Large Group	Day	6	88.00	105.88	55904.64	
PCIS Small Group	Day	23	88.00	105.88	214301.12	
PCIS Facility	Day	20	88.00	105.88	186348.80	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living - Group Home Total:						**1368211716.18**
PCIS - Trial Experience	Day	2	3.00	449.63	**2697.78**	
PCIS - Retainer Fee	Day	869	13.00	449.63	**5079470.11**	
PCIS - Service	Day	1931	353.00	449.63	**306487142.09**	
LTSS - Service	Day	4808	353.00	420.52	**713716636.48**	
LTSS - Retainer Fee	Day	2164	13.00	420.52	**11830068.64**	
LTSS - Trial Experience	Day	2	3.00	338.98	**2033.88**	
LTSS - Dedicated Supports 1:1	15 minutes	2717	11296.00	10.31	**316426601.92**	
LTSS - Dedicated Supports 2:1	15 minutes	126	5648.00	20.61	**14667065.28**	
Day Habilitation Total:						**127876909.96**
PCIS - Day Habilitation	Day	2683	163.00	146.08	**63885020.32**	
Day Habilitation 1:1	15 minutes	1127	1956.00	14.56	**32096238.72**	
Day Habilitation 2:1	15 minutes	31	1956.00	29.14	**1766933.04**	
Day Habilitation Small Group 2-5	15 minutes	1923	1956.00	4.99	**18769326.12**	
Day Habilitation Large Group 6-10	15 minutes	1923	1956.00	3.02	**11359391.76**	
Live-in Caregiver Supports Total:						**15840.00**
Live-in Caregiver Supports	Month	6	12.00	220.00	**15840.00**	
Medical Day Care Total:						**13371561.00**
Medical Day Care	Day	900	147.00	101.07	**13371561.00**	
Personal Supports Total:						**232817033.60**
Personal Supports	15 minutes	5176	3460.00	10.86	**194491305.60**	
Personal					**38325728.00**	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Enhanced Supports	15 minutes	805	3460.00	13.76		
Personal Supports 2:1	n/a	0	0.00	0.01	0.00	
Respite Care Services Total:						19817561.10
Hourly	15 minutes	1370	1400.00	7.88	15113840.00	
Camp	Item	442	1.00	2435.00	1076270.00	
Daily	Day	542	10.00	442.33	2397428.60	
PCIS - Respite Care Services Hourly	Hour	105	350.00	33.47	1230022.50	
Supported Employment (phased out effective years 3, 4, and 5) Total:						12495039.92
Supported Employment (phased out effective years 3, 4, and 5)	Day	671	152.00	122.51	12495039.92	
Assistive Technology and Services Total:						80688.00
Assistive Technology and Services	Item	82	1.00	984.00	80688.00	
Monthly Service Fee	Monthly	0	0.00	0.01	0.00	
Behavioral Support Services Total:						6228016.42
Brief Support Implementation	15 minutes	1424	48.00	18.66	1275448.32	
Plan	Plan	365	1.00	1558.33	568790.45	
Assessment	Assessment	365	1.00	1558.33	568790.45	
Consultation	Hour	2242	48.00	35.45	3814987.20	
Community Development Services Total:						102862467.96
PCIS - Community Development Services	Day	718	147.00	156.86	16555945.56	
LTSS -					44059357.44	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Development Services 1:1	15 minutes	1754	1764.00	14.24		
LTSS - Community Development Services 2:1	15 minutes	65	1764.00	28.48	3265516.80	
LTSS - Community Development Services Small Group	15 minutes	2366	1764.00	9.34	38981648.16	
Community Living - Enhanced Supports Total:						23336910.13
Retainer Fee	Day	29	13.00	694.07	261664.39	
Service	Day	64	353.00	694.07	15680429.44	
Trial Experience	Day	2	3.00	631.17	3787.02	
Dedicated Supports 1:1	15 minutes	46	11296.00	11.48	5965191.68	
Dedicated Supports 2:1	15 minutes	11	5648.00	22.95	1425837.60	
Employment Discovery and Customization (phased out effective years 3, 4, and 5) Total:						32713.08
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	Day	6	41.00	132.98	32713.08	
Employment Services Total:						79932952.29
Discovery Milestone 1	Milestone	220	1.00	685.67	150847.40	
Discovery Milestone 2	Milestone	220	1.00	2057.00	452540.00	
Discovery Milestone 3	Milestone	220	1.00	1371.33	301692.60	
Follow Along Supports	Month	1783	6.00	630.52	6745302.96	
Job Development	15 Minutes	975	598.00	21.42	12488931.00	
On-going Job Supports	15 Minutes	1652	2179.00	16.61	59791149.88	
Co-Worker Employment					1000.00	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports	Month	1	2.00	500.00		
Customized Self-Employment Services	Milestone	3	1.00	496.15	1488.45	
Environmental Assessment Total:						2855.34
Environmental Assessment	Assessment	6	1.00	475.89	2855.34	
Environmental Modifications Total:						98813.00
Environmental Modifications	Item	13	1.00	7601.00	98813.00	
Family and Peer Mentoring Supports Total:						9539.10
Family and Peer Mentoring Supports	15 minutes	31	20.00	14.84	9200.80	
Family and Peer Mentoring Supports (PCIS)	Hour	1	5.00	67.66	338.30	
Family Caregiver Training and Empowerment Services Total:						25000.00
Family Caregiver Training and Empowerment Services	Item	50	1.00	500.00	25000.00	
Housing Support Services Total:						65333.90
Housing Support Services	15 minutes	93	40.00	16.62	61826.40	
Housing Support Services (PCIS)	Hour	5	10.00	70.15	3507.50	
Individual and Family Directed Goods and Services Total:						353720.00
Goods and Services	Item	173	4.00	385.00	266420.00	
Staff Recruitment and Advertising	Item	388	1.00	225.00	87300.00	
Day-to-Day Administrative Support	15 minutes	0	0.00	0.01	0.00	
Nursing Support Services Total:						1733439.60
Nursing					1733439.60	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Services	15 minutes	1146	60.00	25.21		
Participant Education, Training, and Advocacy Supports Total:						**25000.00**
Participant Education, Training, and Advocacy Supports	Item	50	1.00	500.00	**25000.00**	
Remote Support Services Total:						**72000.00**
Remote Support Services	Item	5	12.00	1200.00	**72000.00**	
Shared Living Total:						**12535040.76**
Shared Living Level 1	Month	27	12.00	4046.20	**1310968.80**	
Shared Living Level 2	Month	82	12.00	4644.53	**4570217.52**	
Shared Living Level 3	Month	29	12.00	5542.03	**1928626.44**	
Shared Living (PCIS)	Month	103	12.00	3823.00	**4725228.00**	
Support Broker Services Total:						**8501268.00**
Support Broker Services	Item	1517	12.00	467.00	**8501268.00**	
Supported Living Total:						**72167544.99**
Supported Living	Day	424	353.00	395.42	**59183302.24**	
Dedicated Supports Supported Living 1:1	15 minutes	205	5725.00	10.31	**12100073.75**	
Dedicated Supports Supported Living 2:1	15 minutes	11	3900.00	20.61	**884169.00**	
Transition Services Total:						**114570.00**
Transition Services	Item	57	1.00	2010.00	**114570.00**	
Transportation Total:						**1743600.00**
Transportation	Item	1453	12.00	100.00	**1743600.00**	
Vehicle Modifications Total:						**34375.00**

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	Item	5	1.00	6875.00	34375.00	

GRAND TOTAL: 2086867415.57

Total Estimated Unduplicated Participants: 16365

Factor D (Divide total by number of participants): 127520.16

Average Length of Stay on the Waiver: 353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						2242944.00
LTSS Large Group	15 minutes	52	1056.00	2.66	146065.92	
LTSS Small Group	15 Minutes	361	1056.00	3.54	1349504.64	
LTSS Facility	15 Minutes	124	1056.00	3.94	515919.36	
PCIS Large Group	Day	3	88.00	109.59	28931.76	
PCIS Small Group	Day	11	88.00	109.59	106083.12	
PCIS Facility	Day	10	88.00	109.59	96439.20	
Community Living - Group Home Total:						1583240122.08
PCIS - Trial Experience	Day	2	3.00	465.36	2792.16	
PCIS - Retainer Fee	Day	36	13.00	465.36	217788.48	
PCIS - Service	Day	81	353.00	465.36	13306038.48	
LTSS - Service	Day	6695	353.00	435.24	1028617925.40	
LTSS - Retainer Fee					17047915.56	

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	3013	13.00	435.24		
LTSS - Trial Experience	Day	2	3.00	350.84	2105.04	
LTSS - Dedicated Supports 1:1	15 minutes	4143	11296.00	10.67	499348829.76	
LTSS - Dedicated Supports 2:1	15 minutes	205	5648.00	21.33	24696727.20	
Day Habilitation Total:						125492746.45
PCIS - Day Habilitation	Day	1361	163.00	151.19	33540443.17	
Day Habilitation 1:1	15 minutes	1603	1956.00	15.07	47251502.76	
Day Habilitation 2:1	15 minutes	45	1956.00	30.16	2654683.20	
Day Habilitation Small Group 2-5	15 minutes	2593	1956.00	5.16	26171045.28	
Day Habilitation Large Group 6-10	15 minutes	2593	1956.00	3.13	15875072.04	
Live-in Caregiver Supports Total:						15840.00
Live-in Caregiver Supports	Month	6	12.00	220.00	15840.00	
Medical Day Care Total:						13947546.69
Medical Day Care	Day	907	147.00	104.61	13947546.69	
Personal Supports Total:						242937672.00
Personal Supports	15 minutes	5218	3460.00	11.24	202930107.20	
Personal Supports Enhanced Supports	15 minutes	812	3460.00	14.24	40007564.80	
Personal Supports 2:1	n/a	0	0.00	0.01	0.00	
Respite Care Services Total:						20446231.30
Hourly	15 minutes	1472	1400.00	8.16	16816128.00	
Camp	Item	445	1.00	2435.00	1083575.00	
Daily					2485908.30	

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	543	10.00	457.81		
PCIS - Respite Care Services Hourly	Hour	5	350.00	34.64	60620.00	
Supported Employment (phased out effective years 3, 4, and 5) Total:						1368317.68
Supported Employment (phased out effective years 3, 4, and 5)	Day	71	152.00	126.79	1368317.68	
Assistive Technology and Services Total:						80688.00
Assistive Technology and Services	Item	82	1.00	984.00	80688.00	
Monthly Service Fee	Monthly	0	0.00	0.01	0.00	
Behavioral Support Services Total:						6497276.32
Brief Support Implementation	15 minutes	1435	48.00	19.31	1330072.80	
Plan	Plan	368	1.00	1612.87	593536.16	
Assessment	Assessment	368	1.00	1612.87	593536.16	
Consultation	15 minutes	2260	48.00	36.69	3980131.20	
Community Development Services Total:						116436515.58
PCIS - Community Development Services	Day	18	147.00	162.35	429578.10	
LTSS - Community Development Services 1:1	15 minutes	2264	1764.00	14.74	58867079.04	
LTSS - Community Development Services 2:1	15 minutes	98	1764.00	29.48	5096266.56	
LTSS - Community Development Services Small Group	15 minutes	3051	1764.00	9.67	52043591.88	
Community Living - Enhanced Supports Total:						41063185.48

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Retainer Fee	Day	51	13.00	718.36	476272.68	
Service	Day	114	353.00	718.36	28908243.12	
Trial Experience	Day	2	3.00	718.36	4310.16	
Dedicated Supports 1:1	15 minutes	74	11296.00	11.88	9930539.52	
Dedicated Supports 2:1	15 minutes	13	5648.00	23.75	1743820.00	
Employment Discovery and Customization (phased out effective years 3, 4, and 5) Total:						0.00
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	Day	0	41.00	137.63	0.00	
Employment Services Total:						104715699.80
Discovery Milestone 1	Milestone	252	1.00	709.67	178836.84	
Discovery Milestone 2	Milestone	252	1.00	2129.00	536508.00	
Discovery Milestone 3	Milestone	252	1.00	1419.33	357671.16	
Follow Along Supports	Month	2171	6.00	652.59	8500637.34	
Job Development	15 Minutes	1243	598.00	22.17	16479271.38	
On-going Job Supports	15 Minutes	2100	2179.00	17.19	78659721.00	
Co-Worker Employment Supports	Month	1	2.00	500.00	1000.00	
Customized Self-Employment Services	Milestone	4	1.00	513.52	2054.08	
Environmental Assessment Total:						2955.30
Environmental Assessment	Assessment	6	1.00	492.55	2955.30	
Environmental Modifications Total:						98813.00
Environmental Modifications					98813.00	

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Item	13	1.00	7601.00		
Family and Peer Mentoring Supports Total:						**9873.35**
Family and Peer Mentoring Supports	15 minutes	31	20.00	15.36	**9523.20**	
Family and Peer Mentoring Supports (PCIS)	Hour	1	5.00	70.03	**350.15**	
Family Caregiver Training and Empowerment Services Total:						**25000.00**
Family Caregiver Training and Empowerment Services	Item	50	1.00	500.00	**25000.00**	
Housing Support Services Total:						**67538.30**
Housing Support Services	15 minutes	95	40.00	17.20	**65360.00**	
Housing Support Services (PCIS)	Hour	3	10.00	72.61	**2178.30**	
Individual and Family Directed Goods and Services Total:						**372530.00**
Goods and Services	Item	182	4.00	385.00	**280280.00**	
Staff Recruitment and Advertising	Item	410	1.00	225.00	**92250.00**	
Day-to-Day Administrative Support	15 minutes	0	0.00	0.01	**0.00**	
Nursing Support Services Total:						**1808037.00**
Nursing Support Services	15 minutes	1155	60.00	26.09	**1808037.00**	
Participant Education, Training, and Advocacy Supports Total:						**25000.00**
Participant Education, Training, and Advocacy Supports	Item	50	1.00	500.00	**25000.00**	

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Support Services Total:						**72000.00**
Remote Support Services	Item	5	12.00	1200.00	**72000.00**	
Shared Living Total:						**14584574.52**
Shared Living Level 1	Month	42	12.00	4187.82	**2110661.28**	
Shared Living Level 2	Month	153	12.00	4807.09	**8825817.24**	
Shared Living Level 3	Month	53	12.00	5736.00	**3648096.00**	
Shared Living (PCIS)	Month	0	12.00	38.23	**0.00**	
Support Broker Services Total:						**8983212.00**
Support Broker Services	Item	1603	12.00	467.00	**8983212.00**	
Supported Living Total:						**75270077.56**
Supported Living	Day	427	353.00	409.26	**61688169.06**	
Dedicated Supports Supported Living 1:1	15 minutes	206	5725.00	10.67	**12583664.50**	
Dedicated Supports Supported Living 2:1	15 minutes	12	3900.00	21.33	**998244.00**	
Transition Services Total:						**116580.00**
Transition Services	Item	58	1.00	2010.00	**116580.00**	
Transportation Total:						**1758000.00**
Transportation	Item	1465	12.00	100.00	**1758000.00**	
Vehicle Modifications Total:						**34375.00**
Vehicle Modifications	Item	5	1.00	6875.00	**34375.00**	

GRAND TOTAL: 2361713351.41

Total Estimated Unduplicated Participants: 16498

Factor D (Divide total by number of participants): 143151.49

Average Length of Stay on the Waiver: 353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.*

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						**2690536.62**
LTSS Large Group	15 minutes	12	2474.00	3.98	**118158.24**	
LTSS Small Group	15 Minutes	185	2652.00	4.51	**2212696.20**	
LTSS Facility	15 Minutes	66	1133.00	4.81	**359682.18**	
PCIS Large Group	Day	0	88.00	113.43	**0.00**	
PCIS Small Group	Day	0	88.00	113.43	**0.00**	
PCIS Facility	Day	0	88.00	113.43	**0.00**	
Community Living - Group Home Total:						**1654145758.86**
PCIS - Trial Experience	Day	0	0.00	0.01	**0.00**	
PCIS - Retainer Fee	Day	0	0.00	0.01	**0.00**	
PCIS - Service	Day	0	0.00	0.01	**0.00**	
LTSS - Service	Day	7201	346.00	458.91	**1143395374.86**	
LTSS - Retainer Fee	Day	2376	10.00	458.91	**10903701.60**	
LTSS - Trial Experience	Day	4	3.00	333.84	**4006.08**	
LTSS - Dedicated Supports 1:1	15 minutes	3956	8446.00	12.35	**412642843.60**	
LTSS - Dedicated Supports 2:1	15 minutes	257	13832.00	24.53	**87199832.72**	
Day Habilitation Total:						**226281079.08**
PCIS - Day Habilitation	Day	0	0.00	0.01	**0.00**	
Day Habilitation 1:1	15 minutes	1852	3618.00	18.74	**125568044.64**	
Day Habilitation					**10424801.52**	

GRAND TOTAL: ***3385842107.40***

Total Estimated Unduplicated Participants: ***20573***

Factor D (Divide total by number of participants): ***164576.98***

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
2:1	15 minutes	62	4347.00	38.68		
Day Habilitation Small Group 2-5	15 minutes	4259	2806.00	6.54	78157931.16	
Day Habilitation Large Group 6-10	15 minutes	1831	1648.00	4.02	12130301.76	
Live-in Caregiver Supports Total:						75056.96
Live-in Caregiver Supports	Item	8	11.00	852.92	75056.96	
Medical Day Care Total:						13327605.76
Medical Day Care	Day	658	172.00	117.76	13327605.76	
Personal Supports Total:						683736116.40
Personal Supports	15 minutes	7201	6966.00	10.92	547770852.72	
Personal Supports Enhanced Supports	15 minutes	967	10164.00	13.56	133275653.28	
Personal Supports 2:1	15 minutes	24	7170.00	15.63	2689610.40	
Respite Care Services Total:						22925015.90
Hourly	15 minutes	2002	1329.00	7.86	20912771.88	
Camp	Item	247	1.00	3053.78	754283.66	
Daily	Day	123	19.00	538.28	1257960.36	
PCIS - Respite Care Services Hourly	Hour	0	0.00	0.01	0.00	
Supported Employment (phased out effective years 3, 4, and 5) Total:						0.00
Supported Employment (phased out effective years 3, 4, and 5)	Day	0	0.00	0.01	0.00	
Assistive Technology and Services Total:						329742.72
Assistive Technology	Item	288	1.00	1118.69	322182.72	

GRAND TOTAL: 3385842107.40

Total Estimated Unduplicated Participants: 20573

Factor D (Divide total by number of participants): 164576.98

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Services						
Monthly Service Fee	Month	14	9.00	60.00	7560.00	
Behavioral Support Services Total:						13689022.55
Brief Support Implementation	15 minutes	2469	55.00	22.79	3094768.05	
Plan	Plan	658	1.00	1865.47	1227479.26	
Assessment	Assessment	658	1.00	1868.68	1229591.44	
Consultation	15 Minutes	4135	46.00	42.78	8137183.80	
Community Development Services Total:						477160549.62
PCIS - Community Development Services	Day	0	0.00	0.01	0.00	
LTSS - Community Development Services 1:1	15 minutes	4053	4341.00	14.54	255817821.42	
LTSS - Community Development Services 2:1	15 minutes	267	4402.00	31.20	36670420.80	
LTSS - Community Development Services Small Group	15 minutes	6090	2594.00	11.69	184672307.40	
Community Living - Enhanced Supports Total:						27333710.58
Retainer Fee	Day	19	10.00	780.87	148365.30	
Service	Day	62	332.00	780.87	16073428.08	
Trial Experience	Day	4	3.00	653.02	7836.24	
Dedicated Supports 1:1	15 minutes	56	13477.00	13.02	9826350.24	
Dedicated Supports 2:1	15 minutes	6	8178.00	26.04	1277730.72	
Employment Discovery and Customization (phased out effective years 3, 4, and 5) Total:						0.00

GRAND TOTAL: 3385842107.40

Total Estimated Unduplicated Participants: 20573

Factor D (Divide total by number of participants): 164576.98

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	Day	0	0.00	0.01	0.00	
Employment Services Total:						93577696.06
Discovery Milestone 1	Milestone	206	1.00	950.83	195870.98	
Discovery Milestone 2	Milestone	206	1.00	2847.18	586519.08	
Discovery Milestone 3	Milestone	206	1.00	1867.13	384628.78	
Follow Along Supports	Month	2551	9.00	765.31	17570752.29	
Job Development	15 Minutes	1152	718.00	28.92	23920773.12	
On-going Job Supports	15 Minutes	1913	1269.00	20.97	50906709.09	
Co-Worker Employment Supports	Item	4	1.00	2532.45	10129.80	
Customized Self-Employment Services	Milestone	4	1.00	578.23	2312.92	
Environmental Assessment Total:						79912.80
Environmental Assessment	Assessment	144	1.00	554.95	79912.80	
Environmental Modifications Total:						871330.36
Environmental Modifications	Item	82	1.00	10625.98	871330.36	
Family and Peer Mentoring Supports Total:						88502.19
Family and Peer Mentoring Supports	15 minutes	41	133.00	16.23	88502.19	
Family and Peer Mentoring Supports (PCIS)	Hour	0	0.00	0.01	0.00	
Family Caregiver Training and Empowerment Services Total:						6137.68
Family Caregiver	Item	8	1.00	767.21	6137.68	

GRAND TOTAL: 3385842107.40

Total Estimated Unduplicated Participants: 20573

Factor D (Divide total by number of participants): 164576.98

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training and Empowerment Services						
Housing Support Services Total:						**793393.92**
Housing Support Services	15 minutes	576	66.00	20.87	**793393.92**	
Housing Support Services (PCIS)	Hour	0	0.00	0.01	**0.00**	
Individual and Family Directed Goods and Services Total:						**19420368.20**
Goods and Services	Item	1420	1.00	4749.00	**6743580.00**	
Staff Recruitment and Advertising	Item	226	1.00	283.70	**64116.20**	
Day-to-Day Administrative Support	15 minutes	3240	480.00	8.11	**12612672.00**	
Nursing Support Services Total:						**4778964.96**
Nursing Support Services	15 minutes	1358	129.00	27.28	**4778964.96**	
Participant Education, Training, and Advocacy Supports Total:						**2168.12**
Participant Education, Training, and Advocacy Supports	Item	4	1.00	542.03	**2168.12**	
Remote Support Services Total:						**86023.20**
Remote Support Services	Item	8	1.00	10752.90	**86023.20**	
Shared Living Total:						**10195099.50**
Shared Living Level 1	Month	21	10.00	4554.94	**956537.40**	
Shared Living Level 2	Month	123	10.00	5228.52	**6431079.60**	
Shared Living Level 3	Month	45	10.00	6238.85	**2807482.50**	
Shared Living (PCIS)	Month	0	0.00	0.01	**0.00**	

GRAND TOTAL: 3385842107.40

Total Estimated Unduplicated Participants: 20573

Factor D (Divide total by number of participants): 164576.98

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Broker Services Total:						**9494323.20**
Support Broker Services	15 minutes	3456	160.00	17.17	**9494323.20**	
Supported Living Total:						**121390901.52**
Supported Living	Day	545	312.00	622.99	**105933219.60**	
Dedicated Supports Supported Living 1:1	15 minutes	165	6324.00	12.58	**13126726.80**	
Dedicated Supports Supported Living 2:1	15 minutes	12	7319.00	26.54	**2330955.12**	
Transition Services Total:						**39645.84**
Transition Services	Item	12	1.00	3303.82	**39645.84**	
Transportation Total:						**3199011.84**
Transportation	Item	1728	1.00	1851.28	**3199011.84**	
Vehicle Modifications Total:						**124432.96**
Vehicle Modifications	Item	16	1.00	7777.06	**124432.96**	

GRAND TOTAL: 3385842107.40

Total Estimated Unduplicated Participants: 20573

Factor D (Divide total by number of participants): 164576.98

Average Length of Stay on the Waiver: 358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						**2785586.70**
LTSS Large					**121720.80**	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 minutes	12	2474.00	4.10		
LTSS Small Group	15 Minutes	186	2652.00	4.65	2293714.80	
LTSS Facility	15 minutes	66	1133.00	4.95	370151.10	
PCIS Large Group	Day	0	88.00	117.40	0.00	
PCIS Small Group	Day	0	88.00	117.40	0.00	
PCIS Facility	Day	0	88.00	117.40	0.00	
Community Living - Group Home Total:						1715300453.36
PCIS - Trial Experience	Day	0	0.00	0.01	0.00	
PCIS - Retainer Fee	Day	0	0.00	0.01	0.00	
PCIS - Service	Day	0	0.00	0.01	0.00	
LTSS - Service	Day	7249	346.00	472.68	1185554232.72	
LTSS - Retainer Fee	Day	2392	10.00	472.68	11306505.60	
LTSS - Trial Experience	Day	4	3.00	343.86	4126.32	
LTSS - Dedicated Supports 1:1	15 minutes	3983	8446.00	12.72	427906116.96	
LTSS - Dedicated Supports 2:1	15 minutes	259	13832.00	25.27	90529471.76	
Day Habilitation Total:						234547614.60
PCIS - Day Habilitation	Day	0	0.00	0.01	0.00	
Day Habilitation 1:1	15 minutes	1864	3618.00	19.30	130158273.60	
Day Habilitation 2:1	15 minutes	62	4347.00	39.84	10737437.76	
Day Habilitation Small Group 2-5	15 minutes	4287	2806.00	6.74	81077630.28	
Day Habilitation Large Group 6-10	15 minutes	1843	1648.00	4.14	12574272.96	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live-in Caregiver Supports Total:						**75056.96**
Live-in Caregiver Supports	Item	8	11.00	852.92	**75056.96**	
Medical Day Care Total:						**13831426.44**
Medical Day Care	Day	663	172.00	121.29	**13831426.44**	
Personal Supports Total:						**709591001.34**
Personal Supports	15 minutes	7249	6966.00	11.25	**568086007.50**	
Personal Supports Enhanced Supports	15 minutes	973	10164.00	13.97	**138157320.84**	
Personal Supports 2:1	15 minutes	29	7170.00	16.10	**3347673.00**	
Respite Care Services Total:						**23757901.80**
Hourly	15 minutes	2015	1329.00	8.10	**21691273.50**	
Camp	Item	249	1.00	3053.78	**760391.22**	
Daily	Day	124	19.00	554.43	**1306237.08**	
PCIS - Respite Care Services Hourly	Hour	0	0.00	0.01	**0.00**	
Supported Employment (phased out effective years 3, 4, and 5) Total:						**0.00**
Supported Employment (phased out effective years 3, 4, and 5)	Day	0	0.00	0.01	**0.00**	
Assistive Technology and Services Total:						**335220.10**
Assistive Technology and Services	Item	290	1.00	1118.69	**324420.10**	
Monthly Service Fee	Month	15	12.00	60.00	**10800.00**	
Behavioral Support Services Total:						**14195174.84**
Brief Support Implementation	15 minutes	2485	55.00	23.47	**3207762.25**	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Plan	Plan	663	1.00	1921.43	1273908.09	
Assessment	Assessment	663	1.00	1924.74	1276102.62	
Consultation	15 minutes	4163	46.00	44.06	8437401.88	
Community Development Services Total:						494823858.52
PCIS - Community Development Services	Day	0	0.00	0.01	0.00	
LTSS - Community Development Services 1:1	15 minutes	4080	4341.00	14.98	265314974.40	
LTSS - Community Development Services 2:1	15 minutes	269	4402.00	32.14	38058195.32	
LTSS - Community Development Services Small Group	15 minutes	6130	2594.00	12.04	191450688.80	
Community Living - Enhanced Supports Total:						28153291.20
Retainer Fee	Day	19	10.00	804.30	152817.00	
Service	Day	62	332.00	804.30	16555711.20	
Trial Experience	Day	4	3.00	672.61	8071.32	
Dedicated Supports 1:1	15 minutes	56	13477.00	13.41	10120687.92	
Dedicated Supports 2:1	15 minutes	6	8178.00	26.82	1316003.76	
Employment Discovery and Customization (phased out effective years 3, 4, and 5) Total:						0.00
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	Day	0	0.00	0.01	0.00	
Employment Services Total:						97042797.59
Discovery Milestone 1	Milestone				202725.45	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		207	1.00	979.35		
Discovery Milestone 2	Milestone	207	1.00	2932.60	607048.20	
Discovery Milestone 3	Milestone	207	1.00	1923.14	398089.98	
Follow Along Supports	Month	2568	9.00	788.27	18218496.24	
Job Development	15 Minutes	1160	718.00	29.79	24811495.20	
On-going Job Supports	15 Minutes	1926	1269.00	21.60	52792430.40	
Co-Worker Employment Supports	Item	4	1.00	2532.45	10129.80	
Customized Self-Employment Services	Milestone	4	1.00	595.58	2382.32	
Environmental Assessment Total:						82882.00
Environmental Assessment	Assessment	145	1.00	571.60	82882.00	
Environmental Modifications Total:						881956.34
Environmental Modifications	Item	83	1.00	10625.98	881956.34	
Family and Peer Mentoring Supports Total:						91174.16
Family and Peer Mentoring Supports	15 minutes	41	133.00	16.72	91174.16	
Family and Peer Mentoring Supports (PCIS)	n/a	0	0.00	0.01	0.00	
Family Caregiver Training and Empowerment Services Total:						6137.68
Family Caregiver Training and Empowerment Services	Item	8	1.00	767.21	6137.68	
Housing Support Services Total:						823020.00
Housing Support Services	15 minutes	580	66.00	21.50	823020.00	
Housing					0.00	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Services (PCIS)	n/a	0	0.00	0.01		
Individual and Family Directed Goods and Services Total:						**19925100.60**
Goods and Services	Item	1429	1.00	4749.00	**6786321.00**	
Staff Recruitment and Advertising	Item	228	1.00	283.70	**64683.60**	
Day-to-Day Administrative Support	15 minutes	3262	480.00	8.35	**13074096.00**	
Nursing Support Services Total:						**4955238.30**
Nursing Support Services	15 minutes	1367	129.00	28.10	**4955238.30**	
Participant Education, Training, and Advocacy Supports Total:						**2168.12**
Participant Education, Training, and Advocacy Supports	Item	4	1.00	542.03	**2168.12**	
Remote Support Services Total:						**86023.20**
Remote Support Services	Item	8	1.00	10752.90	**86023.20**	
Shared Living Total:						**10619074.30**
Shared Living Level 1	Month	21	10.00	4691.59	**985233.90**	
Shared Living Level 2	Month	124	10.00	5385.38	**6677871.20**	
Shared Living Level 3	Month	46	10.00	6426.02	**2955969.20**	
Shared Living (PCIS)	n/a	0	0.00	0.01	**0.00**	
Support Broker Services Total:						**9846961.60**
Support Broker Services	15 minutes	3479	160.00	17.69	**9846961.60**	
Supported Living Total:						**125918502.00**
Supported Living	Day	549	312.00	641.68	**109912083.84**	

GRAND TOTAL: 3511070704.81

Total Estimated Unduplicated Participants: 20710

Factor D (Divide total by number of participants): 169535.04

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dedicated Supports Supported Living 1:1	15 minutes	166	6324.00	12.96	13605200.64	
Dedicated Supports Supported Living 2:1	15 minutes	12	7319.00	27.34	2401217.52	
Transition Services Total:						39645.84
Transition Services	Item	12	1.00	3303.82	39645.84	
Transportation Total:						3221227.20
Transportation	Item	1740	1.00	1851.28	3221227.20	
Vehicle Modifications Total:						132210.02
Vehicle Modifications	Item	17	1.00	7777.06	132210.02	

GRAND TOTAL: 3511070704.81
Total Estimated Unduplicated Participants: 20710
Factor D (Divide total by number of participants): 169535.04
Average Length of Stay on the Waiver: 358

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						2986120.78
LTSS Large Group	15 minutes	13	2474.00	4.22	135723.64	
LTSS Small Group	15 Minutes	193	2652.00	4.79	2451694.44	
LTSS Facility	15 Minutes	69	1133.00	5.10	398702.70	
PCIS Large Group	Day	0	88.00	121.50	0.00	

GRAND TOTAL: 3744220645.30
Total Estimated Unduplicated Participants: 21446
Factor D (Divide total by number of participants): 174588.30
Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PCIS Small Group	Day	0	88.00	121.50	0.00	
PCIS Facility	Day	0	88.00	121.50	0.00	
Community Living - Group Home Total:						1829258861.40
PCIS - Trial Experience	Day	0	0.00	0.01	0.00	
PCIS - Retainer Fee	Day	0	0.00	0.01	0.00	
PCIS - Service	Day	0	0.00	0.01	0.00	
LTSS - Service	Day	7506	346.00	486.86	1264412421.36	
LTSS - Retainer Fee	Day	2477	10.00	486.86	12059522.20	
LTSS - Trial Experience	Day	4	3.00	354.18	4250.16	
LTSS - Dedicated Supports 1:1	15 minutes	4124	8446.00	13.10	456290082.40	
LTSS - Dedicated Supports 2:1	15 minutes	268	13832.00	26.03	96492585.28	
Day Habilitation Total:						250080111.80
PCIS - Day Habilitation	Day	0	163.00	167.63	0.00	
Day Habilitation 1:1	15 minutes	1930	3618.00	19.88	138816871.20	
Day Habilitation 2:1	15 minutes	64	4347.00	41.04	11417656.32	
Day Habilitation Small Group 2-5	15 minutes	4439	2806.00	6.94	86443487.96	
Day Habilitation Large Group 6-10	15 minutes	1909	1648.00	4.26	13402096.32	
Live-in Caregiver Supports Total:						84439.08
Live-in Caregiver Supports	Item	9	11.00	852.92	84439.08	
Medical Day Care Total:						14740740.56
Medical Day Care	Day	686	172.00	124.93	14740740.56	

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						**757000363.32**
Personal Supports	15 minutes	7506	6966.00	11.59	**606003965.64**	
Personal Supports Enhanced Supports	15 minutes	1008	10164.00	14.39	**147430039.68**	
Personal Supports 2:1	15 minutes	30	7170.00	16.58	**3566358.00**	
Respite Care Services Total:						**25316505.34**
Hourly	15 minutes	2087	1329.00	8.34	**23132015.82**	
Camp	Item	257	1.00	3053.78	**784821.46**	
Daily	Day	129	19.00	571.06	**1399668.06**	
PCIS - Respite Care Services Hourly	n/a	0	0.00	0.01	**0.00**	
Supported Employment (phased out effective years 3, 4, and 5) Total:						**0.00**
Supported Employment (phased out effective years 3, 4, and 5)	n/a	0	0.00	0.01	**0.00**	
Assistive Technology and Services Total:						**346407.00**
Assistive Technology and Services	Item	300	1.00	1118.69	**335607.00**	
Monthly Service Fee	Month	15	12.00	60.00	**10800.00**	
Behavioral Support Services Total:						**15138496.48**
Brief Support Implementation	15 minutes	2574	55.00	24.17	**3421746.90**	
Plan	Plan	686	1.00	1979.07	**1357642.02**	
Assessment	Assessment	686	1.00	1982.48	**1359981.28**	
Consultation	15 minutes	4311	46.00	45.38	**8999126.28**	
Community Development Services Total:						**527836645.35**

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PCIS - Community Development Services	n/a	0	0.00	0.01	0.00	
LTSS - Community Development Services 1:1	15 minutes	4225	4341.00	15.43	282997386.75	
LTSS - Community Development Services 2:1	15 minutes	279	4402.00	33.10	40652029.80	
LTSS - Community Development Services Small Group	15 minutes	6348	2594.00	12.40	204187228.80	
Community Living - Enhanced Supports Total:						29918261.44
Retainer Fee	Day	19	10.00	828.43	157401.70	
Service	Day	64	332.00	828.43	17602480.64	
Trial Experience	Day	4	3.00	692.79	8313.48	
Dedicated Supports 1:1	15 minutes	58	13477.00	13.81	10794807.46	
Dedicated Supports 2:1	15 minutes	6	8178.00	27.62	1355258.16	
Employment Discovery and Customization (phased out effective years 3, 4, and 5) Total:						0.00
Employment Discovery and Customization (phased out effective years 3, 4, and 5)	n/a	0	0.00	0.01	0.00	
Employment Services Total:						103485815.82
Discovery Milestone 1	Milestone	214	1.00	1008.73	215868.22	
Discovery Milestone 2	Milestone	214	1.00	3020.58	646404.12	
Discovery Milestone 3	Milestone	214	1.00	1980.83	423897.62	
Follow Along Supports	Month	2659	9.00	811.92	19430057.52	
Job Development	15 Minutes	1201	718.00	30.68	26455916.24	

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
On-going Job Supports	15 Minutes	1994	1269.00	22.25	56301088.50	
Co-Worker Employment Supports	Item	4	1.00	2532.45	10129.80	
Customized Self-Employment Services	Milestone	4	1.00	613.45	2453.80	
Environmental Assessment Total:						88312.50
Environmental Assessment	Assessment	150	1.00	588.75	88312.50	
Environmental Modifications Total:						913834.28
Environmental Modifications	Item	86	1.00	10625.98	913834.28	
Family and Peer Mentoring Supports Total:						98481.18
Family and Peer Mentoring Supports	15 minutes	43	133.00	17.22	98481.18	
Family and Peer Mentoring Supports (PCIS)	n/a	0	0.00	0.01	0.00	
Family Caregiver Training and Empowerment Services Total:						6904.89
Family Caregiver Training and Empowerment Services	Item	9	1.00	767.21	6904.89	
Housing Support Services Total:						877140.00
Housing Support Services	15 minutes	600	66.00	22.15	877140.00	
Housing Support Services (PCIS)	n/a	0	0.00	0.01	0.00	
Individual and Family Directed Goods and Services Total:						21039857.20
Goods and Services	Item	1480	1.00	4749.00	7028520.00	
Staff Recruitment and	Item	236	1.00	283.70	66953.20	

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Advertising						
Day-to-Day Administrative Support	15 minutes	3378	480.00	8.60	13944384.00	
Nursing Support Services Total:						5282562.90
Nursing Support Services	15 minutes	1415	129.00	28.94	5282562.90	
Participant Education, Training, and Advocacy Supports Total:						2168.12
Participant Education, Training, and Advocacy Supports	Item	4	1.00	542.03	2168.12	
Remote Support Services Total:						96776.10
Remote Support Services	Item	9	1.00	10752.90	96776.10	
Shared Living Total:						11281180.00
Shared Living Level 1	Month	21	10.00	4832.34	1014791.40	
Shared Living Level 2	Month	129	10.00	5546.94	7155552.60	
Shared Living Level 3	Month	47	10.00	6618.80	3110836.00	
Shared Living (PCIS)	n/a	0	0.00	0.01	0.00	
Support Broker Services Total:						10503465.60
Support Broker Services	15 minutes	3603	160.00	18.22	10503465.60	
Supported Living Total:						134327879.20
Supported Living	Day	568	312.00	660.93	117127370.88	
Dedicated Supports Supported Living 1:1	15 minutes	172	6324.00	13.35	14521168.80	
Dedicated Supports Supported Living 2:1	15 minutes	13	7319.00	28.16	2679339.52	
Transition Services Total:						42949.66
Transition Services	Item	13	1.00	3303.82	42949.66	

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						**3334155.28**
Transportation	Item	1801	1.00	1851.28	**3334155.28**	
Vehicle Modifications Total:						**132210.02**
Vehicle Modifications	Item	17	1.00	7777.06	**132210.02**	

GRAND TOTAL: 3744220645.30

Total Estimated Unduplicated Participants: 21446

Factor D (Divide total by number of participants): 174588.30

Average Length of Stay on the Waiver: 358