

Frequently Asked Questions - Updated June 2027

The Maryland Department of Health's (MDH) Developmental Disabilities Administration (DDA) is implementing changes required to align Maryland's waiver programs with federal Medicaid requirements, Centers for Medicare & Medicaid Services (CMS) guidance, and the FY 2027 budget structure approved through the State's legislative process. Participant and family feedback has been an important part of this process and continues to inform implementation, operational guidance, and support for participants, families, and providers. Throughout the transition, DDA is focused on providing clear information, technical assistance, and resources to help participants and their teams understand the changes, navigate new requirements, and maintain continuity of services to the greatest extent possible.

Q1: What are the cost containment actions included in the FY 2027 DDA Budget?

The FY 2027 budget bill includes several policy and funding-level and/or rate changes focused on strengthening fiscal oversight, supporting equitable access to services across both service delivery models, standardizing service delivery, and aligning program spending with State and federal requirements. As of July 1, 2026, the expected total savings from cost containment actions are approximately \$104M.

1. **Unlicensed Vendor Transition:** The FY 2027 budget requires a cohort of unlicensed vendors to obtain DDA approval as a certified provider to continue delivering applicable services in the self-directed services delivery model.
2. **Targeted Case Management Rate Reduction:** The 2027 budget bill implements a two percent rate reduction to the Targeted Case Management (TCM) reimbursement under Maryland's Medicaid State Plan.
3. **60/40 Rule:** The budget bill includes a new 60/40 policy to cap services at 40 hours per week per individual and 60 hours total per participant across all relatives, legal guardians, and legally responsible persons caregivers, to enhance safeguards for the participant and the staff, reducing the risk of caregiver burnout and lack of backup staffing and ensuring financial accountability of Medicaid waiver funds.
4. **Shared Dedicated Hours:** The technical correction aligns rules governing shared staffing hours in Community Living - Group Home living arrangements across DDA policy and waiver language.
5. **Individual and Family Directed Goods and Services (IFDGS):** The budget includes updates to IFDGS Day-to-Day Administrative Supports to expand the scope to include non-direct supports that assist the individual with household management and scheduling, appointment scheduling, and money management tasks such as reviewing and paying bills and assisting with the maintenance of benefits.
6. **DDA Provider Agency Rates:** The budget bill includes a 2% rate reduction for community providers and reduces the funding **level** for certain support services from 104% of the actuarial rate to 102%.

7. **DDA Self-Directed Reasonable and Customary Standards:** To comply with Maryland's FY 2027 budget bill, Reasonable and Customary Standards payment guidelines will be implemented to align with BLS wage standards used by participants who self-direct services when determining how much to pay employees, unlicensed vendors, individual providers, and provider agencies were updated.

Q2: Why is DDA pursuing cost-containment actions?

DDA service costs have grown by over \$920 million in General Funds and have seen more than 144% growth over the last five years. In that same period, overall enrollment in the Community Pathways Medicaid waiver program has remained steady overall, although enrollment in Self-Directed Services has increased significantly over the same time period.

At the same time, utilization and expenditures for each service delivery model have significantly increased, particularly for personal support services (mostly in the Self-Directed Services delivery model) and dedicated hours via residential services (in the Community Provider-Managed Service delivery model).

Projections for FY 2027 showed that spending would be higher than available funding, which means the agency would need to request additional money to cover the shortfall. The cost-saving steps implemented in FY 2026 were not enough to fix the gap. The Maryland General Assembly passed, and the Governor signed into law, the FY 2027 budget, which included cost-containment measures to align Maryland's waiver programs with federal Medicaid requirements, Centers for Medicare & Medicaid Services (CMS) guidance, and the FY 2027 budget structure approved through the State's legislative process.

Q3: What is driving DDA's cost growth?

DDA's primary cost drivers continue to be:

- Increased utilization of personal supports in the Self-Directed Service model, and dedicated hours for residential services in the Community Provider Managed Service model
- These utilization patterns continue to put pressure on waiver cost neutrality

These trends, if not addressed, threaten the long-term sustainability of services across the system.

Q4: What policy changes are being implemented for the Self-Directed Service delivery (SDS) model ?

Note: These changes do not change the process used to assess a participant's needs or determine the amount of authorized services. Participants will continue to receive services based on individualized assessments, person-centered planning, and identified health and safety needs.

Aligning the Reasonable & Customary (R&C) Methodology

DDA will align the Reasonable & Customary wage methodology with Bureau of Labor Statistics wage standards for Maryland, which are the same standards used in the Community Provider–Managed model.

Elimination of the Wage Exception Process

DDA will eliminate the process that allows participants to request wages above the maximum Reasonable & Customary rate.

Elimination of Wage Table for Unlicensed Vendors

DDA is eliminating the wage table for unlicensed vendors. The vendor wage table will remain only for nursing support services and support brokers. Current unlicensed vendors (individuals and agencies) who provide other services through the Self-Directed Service model and wish to continue providing Medicaid-funded services must submit a DDA provider application and receive DDA approval by August 15, 2026. Alternatively, individuals currently operating as unlicensed vendors could be hired directly as employees by participants self-directing services.

Updates to Family-As-Staff Policies

DDA is implementing limitations on the number of hours that may be paid to legal guardians, relatives, and legally responsible persons for providing waiver services and adding in-laws to the definition of relatives.

SDS Model Budget Methodology

The FY 2027 budget establishes a new, separate rate for self-directed services that removes indirect costs associated with provider-managed agencies. Because self-directed services do not use provider agencies to deliver services, these indirect costs are not applicable to the self-directed model and are not available for participants to spend.

Q5: What policy changes are being implemented for the Community Provider-Managed delivery model?

Enforcement of Dedicated Hours Waiver Requirements

Under current policy, residential providers may use authorized dedicated support hours to support more than one participant in the home when individuals are retired, transitioning between meaningful day services, recovering from a health condition, or receiving fewer than 30 hours of meaningful day services per week. The update is intended to clarify and align the waiver language with current policy, service authorization practices, and the assumptions used in developing residential reimbursement rates.

Rate Reduction

The FY 2027 budget includes a 2% rate reduction for the Community Provider-Managed delivery model.

Updates to Family-As-Staff Policies

The same Family-As-Staff policy updates from the Self-Directed Service model will also apply to the Community Provider-Managed delivery model, in cases where Family-As-Staff services are being delivered through a provider agency.

Q6: Is DDA reducing SDS delivery model participant budgets by 35%?

No, SDS budgets are not being cut by 35%. There is a change in how self-directed service budgets are calculated to align with Centers for Medicare and Medicaid Services (CMS) guidance and the rates included in the Maryland FY 2027 budget.

The proposed waiver amendment sets a Self-Directed Service rate to establish a participant's budget allocation under the Self-Directed Services delivery model. The SDS rate differs from the DDA Provider Rate because the two service delivery models operate differently and include different cost structures.

DDA Provider Rates include cost components associated with operating a provider agency, including program support, general and administrative expenses, and, for certain services, facility costs. These components support activities such as staff supervision, agency administration, billing, human resources, quality assurance, and facility operations.

Under the Self-Directed Service delivery model, participants assume employer and budget authority responsibilities and receive separate supports to assist with those functions. These supports include Financial Management and Counseling Services (FMCS), Support Broker Services, Day-to-Day administrative support, and other waiver services that assist participants with employer and budget management responsibilities. As a result, program support, general and administrative expenses, and facility costs are not included in the SDS rate methodology.

The SDS rate methodology continues to include the cost components applicable to the Self-Directed Service delivery model, including the Direct Support Professional wage, Employer Related Expenses (ERE), training, and transportation, as applicable.

Overall SDS budgets may *appear* lower because they no longer include funding for costs that do not apply to self-directed services. However, this change does not reduce the funding available for approved services in a participant's Person-Centered Plan (PCP) at the established FY 2027 rates. Instead, it ensures that self-directed service rates accurately reflect the costs necessary to support employees and individual providers while meeting federal CMS expectations.

Q7: What changes are coming to unlicensed vendors in the SDS delivery model?

As part of the sustainability package passed by the Maryland General Assembly, DDA is eliminating the wage table for unlicensed vendors. The vendor wage table will remain only for nursing support services and support brokers.

Current unlicensed vendors (individuals and agencies) who provide services through the Self-Directed Services model and wish to continue providing Medicaid-funded services after June 30, 2026, must submit a DDA provider application and receive DDA approval by August 15, 2026. On June 29, DDA announced an extension to the deadline for provider certification to August 15, 2026. Once approved, DDA will issue a provider certification letter and provider number, which will allow the individuals and agencies to bill through the participant's Financial Management and Counseling Services (FMCS) provider. Alternatively, individuals currently operating as unlicensed vendors could be hired directly as employees by Self-Directed Services participants.

It is important to note that this requirement does not apply to individuals or entities providing goods and services through Individual and Family Directed Goods and Services (IFDGS), such as fitness memberships, personal training, aquatics, or horseback riding. These providers are not required to complete the DDA provider application or enrollment process.

At this time, unlicensed vendors who transition to the DDA provider certification process are not required to enroll in ePREP due to the State's transition to the new Maryland Provider Registration and Information Management Enterprise (MPRIME) system. Providers approved by DDA will be required to register in MPRIME in 2027, and DDA will provide additional guidance when that process begins. DDA providers who are already enrolled in ePREP will be subject to the transition requirements under MPRIME.

Individuals with questions should contact their DDA Regional Office Provider Services representative for assistance.

DDA-licensed and certified providers interested in expanding services to participant's self directing provider listings are organized into regional directories on the [Partnering with Providers webpage](#):

- [Central Maryland Regional Office \(CMRO\)](#)
- [Eastern Shore Regional Office \(ESRO\)](#)
- [Southern Maryland Regional Office \(SMRO\)](#)
- [Western Maryland Regional Office \(WMRO\)](#)

Q8: What is cost neutrality, and why did Maryland update the cost neutrality calculations?

The average cost of home and community-based services delivered under the waiver program cannot exceed what Medicaid would pay on average for care in an Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities (ICF-IID)—this is known as cost neutrality. The Maryland Department of Health uses data from the two ICF-IIDs in Maryland (Holly Center and Potomac Center) to determine the cost neutrality threshold for home- and community-based services waiver costs.

Over the last few years, the average per-person cost for the Community Pathways waiver program has increased. The State receives more than \$1.5 billion in federal funds annually for these program services—all of which would be jeopardized if the State failed to meet federal guidelines.

[In FY 2026](#), DDA transitioned to a methodology grounded in actual ICF-IID stays and Medicaid expenditure data. This methodology does not include services funded with 100% state funds or administrative costs. As per CMS guidance, states are to "use the most recent 3-5 years of historical cost and utilization data reported by the state in 372(s) reports to trend cost growth from year-to-year for the five-year projection" (Reference: [Cost Neutrality | Medicaid](#)). Actual Medicaid claims data are used to identify individuals' institutional costs and all other non-ICF-IID Medicaid costs incurred during the stay.

MDH revised cost neutrality calculations to ensure that the program is able to operate in compliance with federal program guidelines. Programs that are not compliant with federal regulations may be subject to emergency service cuts or freezes, which would directly impact the approximately 19,000 Marylanders who DDA serves, as well as their families and service providers. Revisions were made in alignment with best practices and review of [CMS published guidance](#). CMS requires all states operating [Home and Community-Based Services](#) waivers to use a standard cost neutrality methodology and reporting format ([Appendix J](#)).

It is incumbent on state program administrators to ensure the state complies with Medicaid waiver requirements, including cost neutrality. Maryland Medicaid is committed to maintaining program integrity across Medicaid and Medicaid waiver programs, ensuring taxpayer resources are protected and beneficiaries receive accurate, timely services.

Q9: Is the State trying to move people out of community-based services and into institutional care?

The State of Maryland has no intention of institutionalizing participants in the Community Pathways Waiver program.

Both the Community Provider-Managed and Self-Directed Service models are designed to provide supports in the community as an alternative to institutional care, and Medicaid HCBS programs must demonstrate that community-based services are cost-effective and do not exceed the cost of institutional services. Participants may choose either model based on their needs and preferences. This choice is not made by the state.

Maryland remains committed to supporting individuals with developmental disabilities in community-based settings and ensuring participants have access to services that promote independence, choice, and community integration.

Q10: Why does the total amount of approved budgets for person-centered plans exceed the total amount appropriated for DDA services each year?

DDA's appropriation is based on projected utilization using historical actual claims. Approved budgets represent the maximum amount of services participants are authorized to receive based on their person-centered plans.

Many states authorize budgets that exceed actual expenditures because authorized budgets are intended to ensure access under a variety of circumstances to needed services and support participant choice and flexibility. For example, a participant may be authorized for more service hours than they ultimately use so they can adjust their supports as needs change throughout the year. Differences can occur for a variety of reasons, including but not limited to participant choice, workforce, and service availability. As a result, actual spending is often lower than the maximum amount authorized. Participants are not expected to use every dollar in their total budget. Actual spending reflects only the services that are delivered and billed by providers.

The FY 2027 budget includes changes to the budget methodology that are intended to better align approved Self-Directed Service model budgets with applicable cost components and reduce the overstatement that has historically occurred under the prior methodology.

Historically, approved budgets in the Self-Directed Service model have also appeared larger than actual spending because the budget methodology was based on the Community Provider-Managed service delivery model. As a result, approved budgets were designed to give participants flexibility in how they receive services, while still following established service limits and requirements. This has led approved budgets to appear significantly higher than actual expenditures.

