Application for a Â§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 waiverï¿½s 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:
Family Supports Waiver

C. Waiver Number:MD.1466

D. Amendment Number:MD.1466.R02.05

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

07/01/24

Approved Effective Date: 07/01/24
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 correct discrepancies related to portal entry and system functionality to ensure accurate and consistent information between the Community Pathways, Community Supports and Family Supports Waivers. The State intends to make non-substantive updates throughout each appendix noted below so that the Family Supports Waiver is in alignment with the Community Pathways and Community Supports waivers and to make substantive changes to align with the public facing Family Support Waiver document for the approved renewal effective July 2023.

Common terms have been abbreviated after initial use. Number list (e.g., A. B. C. 1. 2. 3. etc.) has been aligned. Paragraph and line spacing were adjusted to support the stakeholder view of information. Duplicative punctuation (e.g., two commas in a row) and duplicative text/sentences were removed (e.g., lights, lights, etc.).

In addition, the following information noted below is in alignment with the public facing Waiver Renewal application track change final versions submitted to the Center for Medicare and Medicaid Services (CMS), which was approved on April 19, 2023.

Reference:
Family Supports Waiver - Renewal 2023 - Information Page -
https://health.maryland.gov/dda/Pages/About/Archives/Waivers/FSW-Renewal-2023.aspx

Appendix A: Waiver Administration and Operations alignments include:

Performance Measure #6 relates to the number of OHCQ death investigations reviewed by OLTSS. See below:

Waiver Renewal 2023 and Public Comment Document
AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ the met requirements. D = # of on-site death investigations reviewed by the OHCQ

Proposed Amendment 2024 - Correct PM language
AA - PM6: # and % of on-site death investigations conducted by the OHCQ 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.

Appendix C: Participant Services alignments include:

1. Personal Supports:
The update to Personal Supports is the limitation that overnight personal supports cannot be provided virtually.

2. Respite Care Services:
Services are reimbursed based on a 15-minute rate for service in the participant’s home or non-licensed respite provider’s home.

3. Transportation Services:
a. OHCDS and FMCS verify qualifications prior to service delivery and continuing thereafter.

4. Appendix C.2:
The State makes payment to a legally responsible individual, who is appropriately qualified, for providing extraordinary care for the following services:
1. Community Development Services
2. Personal Supports

5. Quality Improvement: Performance measure #6 relates to certified providers. See below:

Waiver Renewal 2023 and Public Comment Document
Performance Measure 6 - # and % of non-certified or non-licensed waiver providers who meet training requirements in accordance with the approved waiver.

Proposed Amendment 2024 - Correct PM language
Performance Measure 6 - # and % of certified waiver providers who meet training requirements in accordance with the approved

waiver.

Appendix I: Financial Accountability alignments include:

1. I:2 a
FSW Proposed:
Previous rates from the rate study completed November 2017 have been revised and trended forward with a 9.5% CPI adjustment and will be used for non-FPS services.

2. Proposed and in the Public Comment:
"The foundation of the Brick is the direct support professional wage derived from the State Occupational Employment and Wage Estimate Bureau of Labor Statistics (BLS) data."

3. The amendment language was revised to say, "Included in the rates are five standard cost components…" and the language in the approved renewal also covers all five components.

4. 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.

5. 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.

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**	All (Pasted in uniform information across waivers)
☒ **Appendix A ? Waiver Administration and Operation**	All (Pasted in uniform information across waivers)
☒ **Appendix B ? Participant Access and Eligibility**	All (Pasted in uniform information across waivers)
☒ **Appendix C ? Participant Services**	All (Pasted in uniform information across waivers)
☒ **Appendix D ? Participant Centered Service Planning and Delivery**	All (Pasted in uniform information across waivers)
☒ **Appendix E ? Participant Direction of Services**	All (Pasted in uniform information across waivers)
☒ **Appendix F ? Participant Rights**	All (Pasted in uniform information across waivers)

Component of the Approved Waiver	Subsection(s)
☒ Appendix G ? Participant Safeguards	All (Pasted in uniform information across waivers)
☒ Appendix H	All (Pasted in uniform information across waivers)
☒ Appendix I ? Financial Accountability	All (Pasted in uniform information across waivers)
☒ Appendix J ? Cost-Neutrality Demonstration	All except J-2-d - WY's 1-5

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:

All appendices were touched as language was copied and pasted to ensure consistency and correct discrepancies related to portal entry and system functionality to ensure accurate and consistent information between the Community Pathways, Community Supports and Family Supports Waivers. There were no substantial changes to eligibility or reserved capacity.

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*):

Family Supports 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**

Waiver Number:MD.1466.R02.05
Draft ID: MD.036.02.03

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 Family Supports Waiver is designed to provide support services to participants and their families, which 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 across the participant's lifespan. 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 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 Maryland Department of Health (MDH) is the single state agency ultimately responsible for administering Maryland's Medical Assistance Program. MDH's Office of Long-Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations in the operation and administration of this and other Waiver programs. MDH's Developmental Disabilities Administration (DDA) is the operating state agency administering 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 (HQ) and four Regional Offices (RO) 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's targeted case management (TCM) services are provided by certified Coordination of Community Services provider organizations. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations of many of the DDA's licensed home- and community-based services providers. MDH's Office of Inspector General 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 (TCM) authority. Each Coordinator of Community Services (CCS) assists participants in developing a Person-Centered Plan, which identifies individual health and safety needs and supports that can meet those needs. The CSS 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 Traditional 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) that meet applicable requirements set forth in Appendix C prior to rendering services. For Traditional Services delivery model, individuals and provider organizations are licensed or certified by MDH; for the Self-Directed Services delivery model, the individual or provider organization must be confirmed by the Financial Management and Counseling Services (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 person's own home such as employment services, personal supports, respite, and assistive technology and services must meet provider qualifications to be certified by the DDA. FMCS and Support Broker services are also provided for individuals that use the self-directed service delivery option. 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 (CMS) as a Quality Improvement Organization (QIO) 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; and

4. Administer the DDA's National Core Indicators Surveys.

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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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 also shares information and overview of this Waiver program, including its requirements and services, for these various groups. Prior to development of the amendment, MDH reached out to the Maryland Developmental Disabilities Coalition and the Self-Directed Advocacy Network of Maryland Inc. for input on suggested changes to the waiver for an exception to the electronic visit verification. The Maryland Developmental Disabilities Coalition includes representation from People on the Go (self-advocacy group), the Maryland Developmental Disabilities Council, The ARC of Maryland, Maryland Disability Law Center, and the Maryland Association of Community Services (provider association).

Waiver Renewal Announcement and Dedicated DDA Renewal Webpage

The DDA sent out an announcement of the Amendment on May 30, 2023.
The DDA established a dedicated Waiver Amendment #1 2023 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: Family Supports Waiver - Amendment #1 2023 link: https://tinyurl.com/2s4v93bm

In addition the announcement was posted on the Medicaid Home and Community-Based Services (HCBS) website located at: https://tinyurl.com/4cc5zp9u.

Waiver Amendment Overview

The official public comments period was held from May 31, 2023 through June 30, 2023. The Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on June 1, 2022 of the posting of this application and the public comment period. 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. To support the stakeholder input process and minimize or alleviate stakeholder hardship, all three DDA waiver amendments were submitted together under one response. The DDA received responses from individuals, families, providers, and advocacy agencies.

Public Input Summary

Overwhelmingly, the majority of people agreed with the amendment. A few people disagreed with the amendment. In addition, a few additional recommendations were received related to various services and rates. These recommendations will be considered for future amendments. A summary of the specific recommendations from the public and responses is available on the Waiver Amendment #1 2023 dedicated webpages.

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, Office of Long Term Services and Supports

Agency: Maryland Department of Health

Address: 201 West Preston Street

Address 2: RM 135

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-1442 **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, 4th Floor

Address 2:

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: Jan 6, 2025

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

Last Name: Herrera Scott

First Name: Laura

Title: Secretary

Agency: Maryland Department of Health

Address: 201 W. PRESTON ST.

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone:

(410) 767-5807 **Ext:** ☐ **TTY**

Fax:
(410) 767-6489

E-mail:
laura.herrerascott@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:

As further described in Section II of this Appendix A, this amendment of the this Waiver program includes: (1) updates to the transition strategy for the new Long-Term Services and Supports (LTSSMaryland) fee-for-service billing; and (2) consolidating all standalone nursing support services under the new name of Nursing Support Services therefore removing Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services.

TRANSITION PLANS

1. LONG-TERM SERVICES AND SUPPORTS (LTSSMARYLAND)

The planned transition to DDA's fee-for-service payment methodology, supported by the new software system known as LTSSMaryland, has been delayed due to COVID-19, as reflected in the approved Appendix K. MDH's processing of claims and payments for services funded by this Waiver program on a fee-for-service basis, including updated rates, units, and service requirements, began with a small transition group in December 2019. The new projected completion date is December 31, 2024.

To continue to ensure fiscal payment strategies used within LTSSMaryland are functional, transitions will be implemented using small groups of providers who volunteer to transition. This transition plan will continue to support the live testing of the new detailed service authorization and fee-for service billing functionality in LTSSMaryland and the Medicaid Management Information System (MMIS) prior to full implementing these changes. This testing is being done to reduce the risk of payment issues for all participants and providers.

During the transition period, participants will receive a combination of new services and equivalent legacy service to ensure that their needs and preferences, as documented in the person-centered plan (PCP), are met. Until the DDA billing and payment system is fully transitioned into LTSSMaryland, the DDA will be operating in two systems: LTSSMaryland and the legacy Provider Consumer Information System (PCIS2). Person-centered plans will be completed and approved in LTSSMaryland, and services will be authorized and billed through PCIS2 until they are transitioned. To facilitate service authorization during the transition period, the DDA has developed and published guidance, including a service mapping chart to match the services identified in the detailed service authorization in LTSSMaryland with their equivalent legacy service in PCIS2.Until the service transitions, the legacy service definitions and rates paid for the requested services and the overall authorized plan budget amount is based on rates in PCIS2.

2. NURSING SERVICES

This amendment consolidates the three nursing standalone services (i.e., Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services) under one service titled Nursing Support Services. Stakeholders have expressed confusion as to which of the three nursing services to request. Therefore, Nursing Support Services is being created which will include the current Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services functions. All participants currently authorized Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services will be authorized Nursing Support Services through a coordinated data patch in the LTSSMaryland and PCIS2 systems. Participants will receive the same type and amount of service. The standalone services are basically moved under the umbrella of Nursing Support Services. Participants will have the same choice of provider.

To support these transitions, the DDA will share information, guidance, and technical assistance with all stakeholders, including through the DDA newsletter, transmittals, and webinars. Coordinators of Community Services (CCS) will continue to share information with participants and their families about changes to nursing services during quarterly monitoring, the annual person-centered planning process, and when new needs arise.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB

setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM APPENDIX E.1.a DUE TO SPACE LIMITATIONS**********

FMCS

1. The FMCS 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 FMCS 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 and vendors meet applicable qualifications to render the services as set forth in this Waiver program application and applicable laws and regulations;

b. Facilitating the employment of staff by the participant, along with their team, legal guardian, or designated representative (as applicable);

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, along with their team, legal guardian, or their designated representative (as applicable), and State authorities.

(d) Supported Decision Making

Participants may also seek support with decision making from a specific person or a team of 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.

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 Maryland Department of Health (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. OLTSS and 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. The 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 Waiver program's service data, trends, options to support the Waiver program assurances, financial strategies, and rates.

6. Financial Management and Counseling Services (FMCS)

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

7. Health Risk Screen Tool (HRST)

The DDA contracts with IntellectAbility for training and the use of an electronic 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 (OHCDS) providers

Participants can select to use an 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 at the University of Minnesota (ICI) 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 contract 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.

16. Quality Improvement Organization

The DDA contracts with a certified Quality Improvement Organization (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:

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:

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. Health Risk Screen Tool – 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. Organized Health Care Delivery System 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.*

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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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: Number and percent of annual Quality Reports submitted by DDA, to the OLTSS, in the correct format and timely. N = # of Quality Reports submitted by 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 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 - PM2: Number and percent 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):
Other
If 'Other' is selected, specify:
Reports to State Medicaid Agency on delegated Administrative functions

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: Number and percent of waiver policies approved by the OLTSS. N = Number of waiver policies approved by the OLTSS D = Total number of waiver policies issued.

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**

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: Number and percent 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 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ 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**
☐ **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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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, OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to 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, 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 DDA to address challenges and barriers. Guidance from OLTSS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the challenges or barriers identified. OLTSS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, OLTSS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with 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**
	☐ **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**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	0	21	☐
	☐	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 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 Waiver program, an applicant or participant must meet all of the following technical eligibility requirements:

1. Age: Birth through the end of the school year that the individual turns 21 years old;

2. 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.

3. The individual is not enrolled simultaneously as a participant in another Medicaid Home-and Community-Based Services 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.

4. 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.

5. The 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 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 Waiver program's services such that the individual's health, safety, and welfare can be maintained in the community.

6. The individual complies with applicable Waiver program requirements as set forth in this 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 Waiver program does not provide services during school hours to avoid duplication with services required under IDEA.

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:

At age 18, the Coordinator of Community Services (CCS) and school transition team will support each participant, providing assistance with exploring and transitioning to competitive integrated employment, post-secondary education, employment supports, or meaningful day services.

If needed, participants will be referred to the DDA's other home and community-based services waivers for services, which will include reserved capacity for participants transitioning out of the Family Supports Waiver.

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	525
Year 2	525
Year 3	525
Year 4	525
Year 5	525

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	
Military Families	
Emergency	
Previous Waiver Participants with New Service Need	
Families with Multiple Children on Waiting List	
End the Wait Act 2022	
Crisis Resolution	

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 transitions 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 5 families on the DDA Waiting List will need services. 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	5
Year 2	5
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):*

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 threatens the life and safety of the person.

Describe how the amount of reserved capacity was determined:

Initial estimate assume most applicants that meet this criterion will need a higher level of supports beyond the Family Supports Waiver cap. The estimate will be reassessed with waiver renewal.

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):*

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

Waiver Year	Capacity Reserved
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):*

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. Based on historical data, this slot category was not used. However, there may be instances where a family may have to use these reserved slots. Thus, it is safe to assume it would not exceed the reserved capacity for year 1 through year 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	3
Year 2	3
Year 3	3
Year 4	3
Year 5	3

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 Waiver programs by 50%, the DDA will need to enroll 2,000 participants from the waitlist to a 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	75
Year 4	75
Year 5	75

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	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

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) Military Families; (2) Emergency; (3) Previous Waiver Participants with New Service Need; (4) Families with Multiple Children on the Waiting List; (5) End the Wait Act 2022; and (6) Crisis Resolution.

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.

All individuals determined to meet the crisis resolution category are offered the opportunity to apply to the waiver. 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)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [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 §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 §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 §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 §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)
Infants and children under 19 (42 CFR 435.118)
Reasonable classifications of individuals under 21 (42 CFR 435.222)
Optional targeted low-income children (42 CFR 435.229)

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, 2019 (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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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:

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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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 Targeted Case Management (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 CFR. §1385.3, but redesignated as 45 CFR. §1325.3.

In order to be eligible for the Waiver, applicants must also meet the LOC 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 Waiver program.

Failure to Meet LOC Requirement

If an applicant or current participant is denied eligibility for and 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 LOC 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 an electronic information system, developed and supported by the MDH. It is used to create, review, and maintain records about:

- An individual's eligibility status for DDA-funded services; and
- The individual's person-centered plan, and services and funding authorized by the DDA.

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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 # and % of new enrollees who have an initial LOC determination prior to receipt of waiver services. Numerator = number of new enrollees who have a LOC completed prior to entry into the waiver. Denominator = number of new enrollees.

Data Source (Select one):

Other
If 'Other' is selected, specify:
LTSSMaryland and/or QIO

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: 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: QIO	☐ **Annually**
	☐ **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 =
☒ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: N/A
	☒ **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

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 # and % of LOC initial determinations completed according to State policies and procedures. Numerator = number of LOC initial determinations completed according to State policies and procedures. Denominator = number of initial determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSSMaryland and/or QIO

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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **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 Self-Directed Services 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 Waiver programs. The CCS also provides information regarding service delivery models available under the DDA's Waiver programs. 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. Additionally, interpreter resources are available for individuals who contact the DDA for information, requests for assistance, or complaints. 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	**Personal Supports**		
Statutory Service	**Respite Care Services**		
Supports for Participant Direction	**Support Broker Services**		
Other Service	**Assistive Technology and Services**		
Other Service	**Behavioral Support 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	**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:

Habilitation

Alternate Service Title (if any):

Personal Supports

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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 supports 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 for a child or home for an adult; 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 supports.

C. This 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 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 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 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 unless otherwise authorized by the DDA; or

b. The participant has an approved Nursing Care Plan documenting the need for enhanced supports necessary to support the person with specific health and safety needs unless otherwise authorized by the DDA.

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 unless otherwise authorized by the DDA; or

b. The participant has an approved Nursing Care Plan documenting the need for 2:1 staff-to-participant ratio necessary to support the person with specific health and safety needs unless otherwise authorized by the DDA.

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 unless otherwise authorized by the DDA; or

b. The participant has an approved Nursing Care Plan documenting the need for overnight supports necessary to support the person with specific health and safety needs unless otherwise authorized by the DDA.

5. Overnight supervision supports must be specifically documented within the PCP. 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 unless otherwise authorized by the DDA due to extraordinary circumstances.

D. Personal Support Services includes the provision of supplementary care by legally responsible persons necessary to meet the participant’s extraordinary care needs due to the participant’s disability that are above and beyond the typical, basic care for 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 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.

G. 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.

H. 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.

I. For participants enrolled in the self-directed services delivery model, 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. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the self-directed service 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. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by the 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 must 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.

K. 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 avoiding institutionalization.

L. Personal Supports Services are not available at the same time as the direct provision of Respite Care Services or Transportation Services.

M. 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.

N. 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. If the individual chooses any disability specific classes, activities, events or programs, the choice must be documented in the PCP.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

G. 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.

H. 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.

I. For participants enrolled in the self-directed services delivery model, 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. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the self-directed service 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. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by the 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 must 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.

K. 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 avoiding institutionalization.

L. Personal Supports Services are not available at the same time as the direct provision of Respite Care Services or Transportation Services.

M. 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.

N. 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. If the individual chooses any disability specific classes, activities, events or programs, the choice must be documented in the PCP.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

b. The participant has an approved Nursing Care Plan documenting the need for 2:1 staff-to-participant ratio necessary to support the person with specific health and safety needs unless otherwise authorized by the DDA.

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 unless otherwise authorized by the DDA; or

b. The participant has an approved Nursing Care Plan documenting the need for overnight supports necessary to support the person with specific health and safety needs unless otherwise authorized by the DDA.

5. Overnight supervision supports must be specifically documented within the PCP. 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 unless otherwise authorized by the DDA due to extraordinary circumstances.

D. Personal Support Services includes the provision of supplementary care by legally responsible persons necessary to meet the participant’s extraordinary care needs due to the participant’s disability that are above and beyond the typical, basic care for 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 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.

G. 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.

H. 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.

I. For participants enrolled in the self-directed services delivery model, 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. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the self-directed service 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. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by the 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 must 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.

K. 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 avoiding institutionalization.

L. Personal Supports Services are not available at the same time as the direct provision of Respite Care Services or Transportation Services.

M. 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.

N. 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. If the individual chooses any disability specific classes, activities, events or programs, the choice must be documented in the PCP.

SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

G. 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.

H. 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.

I. For participants enrolled in the self-directed services delivery model, 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. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

d. Mileage reimbursement, under the self-directed service 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. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those services offered by the 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 must 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.

K. 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 avoiding institutionalization.

L. Personal Supports Services are not available at the same time as the direct provision of Respite Care Services or Transportation Services.

M. 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.

N. 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. If the individual chooses any disability specific classes, activities, events or programs, the choice must be documented in the PCP.

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

O. 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 or short-term institutional 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 preserves the participant's functional abilities.

P. Services which are provided virtually, must:

1. 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;

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;

5. Personal Supports overnight supports cannot be provided virtually.

***LIMITS ON THE AMOUNT, FREQUENCY, OR DURATION OF THIS SERVICE LISTED BELOW:

1. Legally responsible person, legal guardians, and relatives may not be paid for greater than 40-hours per week for services unless otherwise approved by the DDA or its designee.

2. Personal Support Services are limited to 82 hours per week under the traditional model unless otherwise preauthorized by the DDA.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Personal Support Professional
Agency	Personal Supports Provider

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 Support 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. 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. 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. Complete and sign any agreements required by the 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 have to complete the DDA provider application. Individuals must submit forms and documentation as required by the FMCS agency. FMCS 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. DDA for certified Personal Support Professional.

2. FMCS providers, as described in Appendix E, for participants 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: 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 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 Personal Supports providers, demonstrate the capability to provide or arrange for the provision of all Personal Supports 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 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 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 as per DDA policy;

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.

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. 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. 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. DDA for approval of certified provider.

2. Provider for verification of staff licenses, certifications, and training.

3. FMCS providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. Provider – Prior to service delivery and continuing thereafter.

3. 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:

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 and as an emergency backup plan for unpaid caregivers. Respite relieves families or other primary caregivers from their daily care giving responsibilities.

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;

4. State certified overnight or youth camps; and

5. Other settings and camps as approved by the DDA.

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.

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 at the same time as the direct provision of Personal Supports, or Transportation Services.

L. 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 COMAR 10.09.20, the Attendant Care Program, and the In-Home Aide Services Program.

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, 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.

N. For participants enrolled in the self-directed services delivery model, 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 service 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 participant 's PCP.

3. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

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 PCP year unless otherwise authorized by the DDA.

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**

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	Respite Care Supports Professional
Agency	Licensed Community Residential Services Provider
Agency	Camp
Agency	OHCDS Provider
Agency	DDA Certified Respite Care Provider

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 DDA 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;

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 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. 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. Complete and sign any agreements required by the 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 FMCS agency. FMCS 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. DDA for approval of Respite Care Supports.

2. FMCS providers, as described in Appendix E, for participants 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: 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 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 residential providers, 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 agencies 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 OHCQ;

G. Be in good standing with the IRS and MDAT;

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 and per DDA policy;

K. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

L. 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 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;

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as

per DDA policy; and

5. Respite Care Services provided in a provider owned and operated residential site must be licensed.

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 16 years old;

2. Possess current First Aid and CPR certification;

3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);

4. 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. Complete necessary pre/in-service training based on the PCP;

7. 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 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;

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. DDA for approval of provider license and licensed site.

2. Licensed Community Residential Services Provider for verification of direct support staff and camps.

3. FMCS providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – 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: 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. Be properly organized as a Maryland corporation or surrounding states, 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 approved camps, demonstrate the capability to provide or arrange for the provision services required by submitting, at a minimum, the following documents with the application:

(1) A program service plan that details the camp's service delivery model;

(2) A summary of the applicant's demonstrated experience;

(3) State certification and licenses as a camp including overnight and youth camps; and

(4) Prior licensing reports issued within the previous 5 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If a currently approved camp, 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. Required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Require 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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of camps.

2. FMCS providers, as described in Appendix E. for participants 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: 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 certified or licensed by the DDA to provide at least one Medicaid Waiver service; and

2. Complete the DDA provider application to be an OHCDS provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs 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;

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 PCP;

6. 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 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.

Camp requirements including:

1. Be a certified OHCDS provider;

2. Have State certification and licenses as a camp, including overnight and youth camps as per COMAR 10.16.06, unless otherwise approved by the DDA; and

3. Be a DDA approved camp.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of OHCDS.

2. OHCDS providers for verification of entities and individuals they contract or employ.

3. FMCS providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. OHCDS – Initially and at least every 3 years.

2. OHCDS providers – Prior to service delivery and continuing thereafter.

3. FMCS – 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:

DDA Certified Respite Care 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 certified respite care providers, 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 agencies 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 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.

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 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;

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 PCP;

6. 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 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.

Camp requirements including:

1. Be a certified OHCDS provider;

2. Have State certification and licenses as a camp, including overnight and youth camps as per COMAR 10.16.06, unless otherwise approved by the DDA; and

3. Be a DDA approved camp.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of provider.

2. Respite Care Services Provider for verification of direct support staff and camps.

3. FMCS providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. DDA Certified Respite Care Services Provider – prior to service delivery and continuing thereafter.

3. FMCS – 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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
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 in:

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 the including:

a. Assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services;

b. Assists the participant (or the participant's family or representative, as appropriate) in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services.

c. Practical skills training to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving.

d. Providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service implementation plan.

B. Support Broker Services can be employer related information and advice for a participant in support of self-direction to make informed decisions related to day-to-day management of staff providing services within the available budget.

C. Information, coaching, and mentoring may be provided to participant about:

1. Self-direction including roles and responsibilities and functioning as the common law employer;

2. Other employment related subjects pertinent to the participant and/or family in managing and directing services;

3. Person-Centered planning and how it is applied;

4. The range and scope of individual choices and options;

5. The process for changing the PCP and individual budget;

6. The grievance process;

7. Risks and responsibilities of self-direction;

8. Policy on Reportable Incidents and Investigations (PORII);

9. Free choice of providers, including control over the selection and hiring of qualified individuals as workers;

10. Individual and employer rights and responsibilities;

11. The reassessments and review of work schedules; and

12. Other subjects pertinent to the participant in managing and directing waiver services.

D. Assistance, as necessary and appropriate, if chosen by the participant, may be provided with:

1. Defining goals, needs, and preferences;

2. Identifying resources and accessing services, supports and resources;

3. Practical skills training (e.g., hiring, managing, and terminating workers, problem solving, conflict resolution);

4. Development of risk management agreements;

5. Development of an emergency back- up plan;

6. Recognizing and reporting critical events;

7. Independent advocacy, to assist in filing grievances and complaints when necessary;

8. Developing strategies for recruiting, interviewing, and hiring staff;

9. Developing staff supervision and evaluation strategies;

10. Developing terminating strategies;

11. Developing employer related risk assessment, planning, and remediation strategies;

12. Developing strategies for managing the budget and budget modifications including reviewing monthly FMCS reports to ensure that the individualized budget is being spent in accordance with the approved PCP and budget and conducting audits;

13. Developing strategies for managing employees, supports and services;

14. Developing strategies for facilitating meetings and trainings with employees;

15. Developing service quality assurance strategies;

16. Developing strategies for reviewing data, employee timesheets, and communication logs;

17. Developing strategies for effective staff back-up and emergency plans;

18. Developing strategies for training all of the participant’s employees on the PORII and ensuring that all critical incidents are reported to the OHCQ and DDA; and

19. Developing strategies for complying with all applicable regulations and policies, as well as standards for self-direction including staffing requirements and limitations as required by the DDA.

SERVICE REQUIREMENTS:

A. Support Broker Services are an optional service to support participants enrolled in the Self-Directed Service 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.

B. Support Broker Services are required 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.

C. 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 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 Waiver program.

2. A relative who is paid to provide Support Broker services cannot:

a. Provide this Waiver program service for more than 40 hours a week;

b. Serve as the participant's designated representative, managing the participant's self-directed services as provided in Appendix E; or

c. Provide any other Waiver program services which are funded by the Waiver program under this Appendix C.

D. Support Brokers must provide assurances that they will implement the PCP 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.

E. Individuals and organizations providing Support Broker Services may provide no other paid service to that participant.

F. Support Broker Services may not duplicate, replace, or supplant Coordination of Community Service.

G. 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.

H. 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-directed service model requirements.

I. Service hours must be necessary, documented, and evaluated by the team.

J. Support Brokers shall not make any decision for the participant, sign off on their own timesheets or invoices, or hire or fire workers.

K. This service includes the option to provide benefits and leave time to a Support Broker subject to the following requirements:

1. The Support Broker is an employee of the participant.

2. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;

3. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local laws; and

4. Cost for training, mileage, benefits, and leave time are allocated from the participant's total annual budget allocation.

2. A relative who is paid to provide Support Broker services cannot:

a. Provide this Waiver program service for more than 40 hours a week;

b. Serve as the participant's designated representative, managing the participant's self-directed services as provided in Appendix E; or

c. Provide any other Waiver program services which are funded by the Waiver program under this Appendix C.

D. Support Brokers must provide assurances that they will implement the PCP 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.

E. Individuals and organizations providing Support Broker Services may provide no other paid service to that participant.

F. Support Broker Services may not duplicate, replace, or supplant Coordination of Community Service.

G. 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.

H. 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-directed service model requirements.

I. Service hours must be necessary, documented, and evaluated by the team.

J. Support Brokers shall not make any decision for the participant, sign off on their own timesheets or invoices, or hire or fire workers.

K. This service includes the option to provide benefits and leave time to a Support Broker subject to the following requirements:

1. The Support Broker is an employee of the participant.

2. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;

3. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local laws; and

4. Cost for training, mileage, benefits, and leave time are allocated from the participant's total annual budget allocation.

2. Identifying resources and accessing services, supports and resources;

3. Practical skills training (e.g., hiring, managing, and terminating workers, problem solving, conflict resolution);

4. Development of risk management agreements;

5. Development of an emergency back- up plan;

6. Recognizing and reporting critical events;

7. Independent advocacy, to assist in filing grievances and complaints when necessary;

8. Developing strategies for recruiting, interviewing, and hiring staff;

9. Developing staff supervision and evaluation strategies;

10. Developing terminating strategies;

11. Developing employer related risk assessment, planning, and remediation strategies;

12. Developing strategies for managing the budget and budget modifications including reviewing monthly FMCS reports to ensure that the individualized budget is being spent in accordance with the approved PCP and budget and conducting audits;

13. Developing strategies for managing employees, supports and services;

14. Developing strategies for facilitating meetings and trainings with employees;

15. Developing service quality assurance strategies;

16. Developing strategies for reviewing data, employee timesheets, and communication logs;

17. Developing strategies for effective staff back-up and emergency plans;

18. Developing strategies for training all of the participant’s employees on the PORII and ensuring that all critical incidents are reported to the OHCQ and DDA; and

19. Developing strategies for complying with all applicable regulations and policies, as well as standards for self-direction including staffing requirements and limitations as required by the DDA.

SERVICE REQUIREMENTS:

A. Support Broker Services are an optional service to support participants enrolled in the Self-Directed Service 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.

B. Support Broker Services are required 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.

C. 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 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 Waiver program.

2. A relative who is paid to provide Support Broker services cannot:

a. Provide this Waiver program service for more than 40 hours a week;

b. Serve as the participant's designated representative, managing the participant's self-directed services as provided in Appendix E; or

c. Provide any other Waiver program services which are funded by the Waiver program under this Appendix C.

D. Support Brokers must provide assurances that they will implement the PCP 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.

E. Individuals and organizations providing Support Broker Services may provide no other paid service to that participant.

F. Support Broker Services may not duplicate, replace, or supplant Coordination of Community Service.

G. 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.

H. 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-directed service model requirements.

I. Service hours must be necessary, documented, and evaluated by the team.

J. Support Brokers shall not make any decision for the participant, sign off on their own timesheets or invoices, or hire or fire workers.

K. This service includes the option to provide benefits and leave time to a Support Broker subject to the following requirements:

1. The Support Broker is an employee of the participant.

2. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;

3. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local laws; and

4. Cost for training, mileage, benefits, and leave time are allocated from the participant's total annual budget allocation.

2. A relative who is paid to provide Support Broker services cannot:

a. Provide this Waiver program service for more than 40 hours a week;

b. Serve as the participant's designated representative, managing the participant's self-directed services as provided in Appendix E; or

c. Provide any other Waiver program services which are funded by the Waiver program under this Appendix C.

D. Support Brokers must provide assurances that they will implement the PCP 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.

E. Individuals and organizations providing Support Broker Services may provide no other paid service to that participant.

F. Support Broker Services may not duplicate, replace, or supplant Coordination of Community Service.

G. 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.

H. 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-directed service model requirements.

I. Service hours must be necessary, documented, and evaluated by the team.

J. Support Brokers shall not make any decision for the participant, sign off on their own timesheets or invoices, or hire or fire workers.

K. This service includes the option to provide benefits and leave time to a Support Broker subject to the following requirements:

1. The Support Broker is an employee of the participant.

2. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;

3. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local laws; and

4. Cost for training, mileage, benefits, and leave time are allocated from the participant's total annual budget allocation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

PCP authorization for:

1. Initial orientation and assistance up to 15 hours.

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**

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: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:

Individual

Provider Type:

Support Broker Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must meet the following standards:

1. Be at least 18 years old;

2. 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. 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.

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; and

7. Complete required orientation and training designated by DDA including the PORII and Support Broker trainings.

Individuals must submit forms and documentation as required by the FMCS agency. FMCS 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. FMCS provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. FMCS provider – Prior to service delivery and continuing thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
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:

1. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

2. A minimum of 5 years demonstrated experience and capacity providing quality similar services;

3. 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;

4. Except for currently DDA licensed or certified 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:

A. A program service plan that details the agencies service delivery model;

B. A business plan that clearly demonstrates the ability of the agency to provide 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.

5. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D.

6. Be in good standing with the IRS and MDAT;

7. Have Workers' Compensation Insurance;

8. Have Commercial General Liability Insurance;

9. 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;

10. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

11. Complete required orientation and training;

12. Comply with the DDA standards related to provider qualifications; and

13. Complete and sign any agreements required by the MDH or DDA.

14. Have documentation that all vehicles used in the provision of services have automobile insurance; and

15. 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. 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.

3. Complete required orientation and training designated by DDA including the PORII and Support Broker trainings;

4. Complete necessary pre/in-service training based on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information as noted in the PCP and DDA required training prior to service delivery;

5. Possess current First Aid and CPR certification;

6. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

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.

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. 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.

3. Complete required orientation and training designated by DDA including the PORII and Support Broker trainings;

4. Complete necessary pre/in-service training based on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information as noted in the PCP and DDA required training prior to service delivery;

5. Possess current First Aid and CPR certification;

6. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

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. FMCS 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. Provider – Prior to service delivery and annually 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 Â§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. The purpose of Assistive Technology 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; and

4. 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. Remote support devices, such as Assistive Technology health monitoring such as blood pressure bands and oximeter and personal emergency response systems; 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 Person-Centered Plan (PCP); and

7. Services consisting of purchasing or leasing 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 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 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, must be selected for inclusion on the PCP unless an explanation of why the chosen option is the most cost effective.

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, including those services offered by Maryland Medicaid State Plan, Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), and Department of Human Services (DHS) or any other federal, or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be written 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 written 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.

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 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.
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.

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 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 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, must be selected for inclusion on the PCP unless an explanation of why the chosen option is the most cost effective.

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, including those services offered by Maryland Medicaid State Plan, Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), and Department of Human Services (DHS) or any other federal, or State government funding program must be explored and exhausted to the extent applicable.

1. These efforts must be written 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 written 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.

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 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.

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.

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**

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
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:

OHCDS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and

2. Complete the DDA 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.

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. RESNA ATP;

b. CSUN Assistive Technology Applications Certificate; or

c. 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 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; or

c. CCC-SLP; and

d. Minimum of 3 years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. 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 DORS as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of OHCDS.

2. OHCDS providers for entities and individuals they contract or employ.

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: 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 DDA provider application and be certified 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. Complete required orientation and training designated by DDA;

6. 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 values in Annotated Code of Maryland, Health General, Title 7;

8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;

9. Complete and sign any agreements required by MDH or DDA and

10. Have a signed Medicaid Provider Agreement.

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. Needs assessment and recommendation must be completed by a licensed Speech Therapist;

b. Program and training can be conducted by a RESNA ATP 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; or

c. CCC-SLP; and

d. Minimum of 3 years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. 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 DORS as an Assistive Technology service vendor.

4. 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 DORS as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA 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. DDA – Initially and at least every 3 years.

2. FMCS 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 Â§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:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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 challenging 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, discussing the information with the participant's support team, and developing a Behavior Support Plan that best addresses the function of the behavior, if needed;

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 modeling 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 (if applicable);

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 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 recording the history of the challenging behaviors and attempts to modify it;

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, if applicable, with goals that are specific, measurable, attainable, relevant, time based, and based on a person-centered approach;

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. Consultation, subsequent to the development of the Behavioral Support Plan which may include speaking with the participant's Psychiatrists and other medical/therapeutic practitioners;

3. Developing, writing, presenting, and monitoring the strategies for working with the participant and their caregivers;

4. 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, activities, and ways to communicate with and support the participant;

5. 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;

6. Ongoing assessment of progress in all appropriate environments against identified goals related to the Behavioral Support Plan.

7. 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 for the participant;

c. Data, trend analysis and graphs to detail progress on target behaviors identified in a Behavior Support Plan; and

d. Recommendations for ongoing supports;

8. Development and updates to the Behavior Support Plan as required by regulations; and

9. 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 their identified goals.

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., 1:1 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 and guidance 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, 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.

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 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 is 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 Waiver program service.

N. Services which are provided virtually, must:

1. 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;

2. Support a participant to reach outcomes identified 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:

1. Behavioral Assessment and Behavior Support Plan is limited to 1 per PCP year, unless otherwise approved by the DDA.

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**

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 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 Behavioral Support Services providers, 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 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 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.

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 the Council on Quality and Leadership (CQL) or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation (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. 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 professional counselor;

4. LCSW; and

5. LBA.

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 the I/DD population;

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, including positive reinforcement/schedules of reinforcement;

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. Demonstrated completion of high school or equivalent/higher,

2. Successfully completed a 40-hour behavioral technician training, and

3. 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. DDA for approval of Behavioral Support Services provider.

2. Providers for verification of clinician's and staff qualifications and training.

Frequency of Verification:

1. DDA - 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 DDA provider application and be certified 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, Department, 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.

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 professional counselor;

4. Licensed Certified Social Worker (LCSW); or

5. Licensed Behavioral Analysis (LBA).

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 the I/DD population;

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, including positive reinforcement/schedules of reinforcement;

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. Demonstrated completion of high school or equivalent/higher,

2. Successfully completed a 40-hour behavioral technician training; and

3. Receives ongoing supervision by a qualified clinician who meets the criteria to provide the Behavioral Assessment and Behavioral Consultation.

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. Demonstrated completion of high school or equivalent/higher,

2. Successfully completed a 40-hour behavioral technician training; and

3. 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. DDA for approval of certified Behavioral Support Services Professional.

2. FMCS provider, as described in Appendix E for participants 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 Â§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 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.

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 Coordinator of Community Service (CCS) in an accessible format.

D. 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.

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 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 Waiver program service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Environment Assessment is limited to 1 assessment annually unless otherwise authorized by the DDA.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Environmental Assessment Professional
Agency	OHCDS

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:

Environmental Assessment 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. Be a licensed Occupational Therapist by the Maryland Board of Occupational Therapy Practice or 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. Complete required orientation and training designated by the DDA;

6. 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 values in Annotated Code of Maryland, Health General, Title 7;

8. Demonstrate financial integrity through IRS, Department, 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the certified Environmental Assessment Professional.

2. FMCS provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS provider – Prior to initial services 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:

Agency

Provider Type:

OHCDS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be certified or licensed by the DDA 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, 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. DDA for approval of the OHCDS.

2. OHCDS provider will verify Occupational Therapist (OT) License and DORS approved vendor.

Frequency of Verification:

1. DDA - Initially and at least every 3 years.

2. OHCDS - 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 Â§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;

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 Waiver 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. Unless otherwise approved by the DDA, 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.

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 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 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 FMCS provider, and, if applicable, the property owner.

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 Waiver program, either directly or indirectly, to provide this Waiver program service.

G. 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.

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 avoiding institutionalization.

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 Waiver 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. Unless otherwise approved by the DDA, 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.

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 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 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 FMCS provider, and, if applicable, the property owner.

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 Waiver program, either directly or indirectly, to provide this Waiver program service.

G. 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.

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 avoiding institutionalization.

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 unless otherwise authorized by the DDA.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Environmental Modification Professional
Agency	OHCDS

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 Modification 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. Be a licensed home contractor or DORS approved vendor;

3. Be properly licensed or certified by the State;

4. Obtain and maintain Commercial General Liability Insurance;

5. Obtain and maintain worker's compensation insurance sufficient to cover all employees, if any;

6. Be bonded as is legally required;

7. Complete required orientation and training designated by DDA;

8. 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;

9. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;

10. Complete and sign any agreements required by the MDH or DDA; and

11. Have a signed Medicaid Provider Agreement.

Environmental Modification Professional shall:

1. Ensure all staff, contractors and subcontractors meet required qualifications including verifying the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;

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

3. Ensure all home contractors and subcontractors of services shall:

a. Be properly licensed or certified by the State;

b. Be in good standing with the MDAT to provide the service;

c. Maintain Commercial General Liability Insurance; and

d. Obtain and maintain worker's compensation insurance sufficient to cover all employees, if required by law and

e. Be bonded as is legally required.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the certified Environmental Modifications professional.

2. FMCS providers, as described in Appendix E, for participants 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

OHCDS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and

2. Complete the DDA 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. Be licensed home contractors or DORS approved vendors;

2. All staff, contractors and subcontractors meet required qualifications including verifying the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;

3. 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

4. All home contractors and subcontractors of services shall:

a. Be properly licensed or certified by the State;

b. Be in good standing with the MDAT to provide the service;

c. Obtain and maintain Commercial General Liability Insurance; and

d. Obtain and maintain worker's compensation insurance sufficient to cover all employees, if required by law;

e. Be bonded as is legally required.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the OHCDS.

2. OHCDS provider for approval of the contractors and subcontractors to meet required qualifications.

Frequency of Verification:

1. DDA – 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: 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 Â§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 provide mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and their family members. Family and Peer mentors explain community services, programs, and strategies they have used to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and their family.

B. 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.

C. Family and Peer Mentoring Supports includes:

1. Facilitation of connection between:

i. The participant and the participant's relatives; and

ii. A mentor; and

2. Follow-up support to assure the match between the mentor and the participant and the participant's relatives meets peer expectations.

D. Family and Peer Mentoring Supports do not include:

1. Provision of Coordination of Community Services;

2. Determination of participant eligibility for enrollment in the Waiver program, as described in Appendix B;

3. Development of the PCP, as described in Appendix D;

4. Support Broker Services, as described in Appendices C and E.

SERVICE REQUIREMENTS:

A. Family and Peer Mentoring Supports are provided from an experienced peer mentor, parent or other family member to a peer, another parent or family caregiver who is the primary unpaid support to the participant.

B. Support needs for peer mentoring are identified in the participant's PCP.

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 Waiver program, either directly or indirectly, to provide this Waiver program service.

1. 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.

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.

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**

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	Familiy 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:

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 with providing quality similar services such as self-advocacy and parent organizations;

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 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.

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 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 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 a Bachelor's Degree or demonstrated life experiences and skills to provide the service;

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 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. DDA for approval of the Family and Peer Mentoring Provider.

2. Family and Peer Mentoring Provider for verification of staff standards.

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: Family and Peer Mentoring Supports

Provider Category:

Individual

Provider Type:

Familiy or Peer Mentor

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. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;

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. 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 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 approval of the certified Family and Peer Mentors.

2. FMCS provider, as described in Appendix E, for participants 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 Â§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 PCP.

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, 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.

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 avoiding institutionalization.

D. 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. Family Caregiver Training and Empowerment Services are limited to a maximum of 10 hours of training for unpaid family caregiver per participant per year.

2. Educational materials and training programs, workshops and conferences registration costs for unpaid family caregiver is limited to up to $500 per participant per year.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Parent Support Agency
Individual	Family Support Professional

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 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 with 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. 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 certified, to 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 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 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 a Bachelor's Degree, professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;

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. DDA for approval of Parent Support Agencies.

2. Parent Support Agency for staff qualifications and requirements.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. Parent Support Agency – Prior to service delivery and continuing.

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 DDA provider application and be certified 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. Complete required orientation and training designated by DDA;

4. 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;

5. Demonstrate financial integrity through IRS, Department, 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. DDA for approval of certified Family Supports Professional.

2. FMCS provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS – 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 Â§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:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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, criminal background, and behaviors; and

10. Assistance with resolving disputes.

D. Housing Transition Services includes:

1. Conducting a tenant 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 PCP or record 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.

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 PCP.

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 Waiver program, either directly or indirectly, to provide this Waiver program service.

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.

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 PCP.

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 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:

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**

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 Services 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 Services 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 Housing Support Services to persons with disabilities who successfully transitioned to independent renting or similar services;

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 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.

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.

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 a GED or high school diploma;

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 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 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. DDA for approval of provider.

2. Provider for verification of staff requirements.

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: Housing Support Services

Provider Category:

Individual

Provider Type:

Housing Support 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. Have GED or high school diploma;
3. Training in the following:

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.

4. Possess current First Aid and CPR certification;

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. Complete required orientation and training designated by the DDA;

9. 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 values in Annotated Code of Maryland, Health General, Title 7;

11. Demonstrate financial integrity through IRS, Department, 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. DDA for approval of Housing Support Professional.

2. FMCS providers for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS – 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 Â§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 waiver or through the Medicaid State Plan that address an identified need in a participant's PCP, which includes improving and maintaining the individual'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 programs and activities that 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;

4. Laundry appliances (washer and/or dryer) to promote independence and self-care, if none exist in the home;

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. Day to day administrative supports which include assistance with all aspects of household and personal management essential to maintain community living, including support with scheduling and maintaining appointments and money management;

9. Fitness items that can be purchased at most retail stores;

10. Toothbrushes or electric toothbrushes;

11. Weight loss program services other than food;

12. Dental services recommended by a licensed dentist and not covered by health insurance;

13. Nutritional consultation and supplements recommended by a professional licensed in the relevant field;

14. Internet services; and

15. Other goods and services that meet this Waiver service requirements.

F. Experimental or prohibited goods and treatments are excluded.

G. IFDGS do not include 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 waiver or the Medicaid State Plans;

3. Additional units or costs beyond the maximum allowable for any Waiver 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 solely 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, marijuana, or illegal drugs;

13. Vacation expenses and travel adventures;

14. Insurance; vehicle maintenance or any other transportation- related expenses;

15. Tickets and related cost to attend recreational events;

16. Personal clothing and shoes;

17. Haircuts, nail services, and spa treatments;

18. Goods or services with costs that significantly exceed community norms for the same or similar good or service;

19. Tuition including post-secondary credit and noncredit courses, educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home-schooling activities and supplies;

20. Staff bonuses and housing subsidies;

21. Subscriptions;

22. Training provided to paid caregivers;

23. Services in hospitals;

24. Costs of travel, meals, and overnight lodging for staff, families, and natural support network members to attend a training event or conference;

25. Service animals and associated costs;

26. Exercise rooms, swimming pools, and hot tubs;

27. Fines, debts, legal fees or advocacy fees;

28. Contributions to ABLE Accounts and similar saving accounts;

29. Country club membership or dues;

30. Leased or purchased vehicles; or

31. Items purchased prior to the approved PCP.

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 Waiver program service must be documented in the participant's PCP and authorized by the DDA or its designee in accordance with applicable policy.

I. The goods and services must provide or direct an exclusive benefit to the participant.

J. 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).

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

L. 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.

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, 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.

N. 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 avoiding institutionalization.

O. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the FMCS.

P. 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. The one exception is for the Day-to-Day Administrative Support where a relative can provide the support if selected by the person.

24. Costs of travel, meals, and overnight lodging for staff, families, and natural support network members to attend a training event or conference;

25. Service animals and associated costs;

26. Exercise rooms, swimming pools, and hot tubs;

27. Fines, debts, legal fees or advocacy fees;

28. Contributions to ABLE Accounts and similar saving accounts;

29. Country club membership or dues;

30. Leased or purchased vehicles; or

31. Items purchased prior to the approved PCP.

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 Waiver program service must be documented in the participant's PCP and authorized by the DDA or its designee in accordance with applicable policy.

I. The goods and services must provide or direct an exclusive benefit to the participant.

J. 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).

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

L. 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.

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, 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.

N. 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 avoiding institutionalization.

O. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the FMCS.

P. 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. The one exception is for the Day-to-Day Administrative Support where a relative can provide the support if selected by the person.

15. Other goods and services that meet this Waiver service requirements.

F. Experimental or prohibited goods and treatments are excluded.

G. IFDGS do not include 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 waiver or the Medicaid State Plans;

3. Additional units or costs beyond the maximum allowable for any Waiver 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 solely 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, marijuana, or illegal drugs;

13. Vacation expenses and travel adventures;

14. Insurance; vehicle maintenance or any other transportation- related expenses;

15. Tickets and related cost to attend recreational events;

16. Personal clothing and shoes;

17. Haircuts, nail services, and spa treatments;

18. Goods or services with costs that significantly exceed community norms for the same or similar good or service;

19. Tuition including post-secondary credit and noncredit courses, educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home-schooling activities and supplies;

20. Staff bonuses and housing subsidies;

21. Subscriptions;

22. Training provided to paid caregivers;

23. Services in hospitals;

24. Costs of travel, meals, and overnight lodging for staff, families, and natural support network members to attend a training event or conference;

25. Service animals and associated costs;

26. Exercise rooms, swimming pools, and hot tubs;

27. Fines, debts, legal fees or advocacy fees;

28. Contributions to ABLE Accounts and similar saving accounts;

29. Country club membership or dues;

30. Leased or purchased vehicles; or

31. Items purchased prior to the approved PCP.

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 Waiver program service must be documented in the participant's PCP and authorized by the DDA or its designee in accordance with applicable policy.

I. The goods and services must provide or direct an exclusive benefit to the participant.

J. 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).

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

L. 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.

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, 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.

N. 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 avoiding institutionalization.

O. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the FMCS.

P. 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. The one exception is for the Day-to-Day Administrative Support where a relative can provide the support if selected by the person.

24. Costs of travel, meals, and overnight lodging for staff, families, and natural support network members to attend a training event or conference;

25. Service animals and associated costs;

26. Exercise rooms, swimming pools, and hot tubs;

27. Fines, debts, legal fees or advocacy fees;

28. Contributions to ABLE Accounts and similar saving accounts;

29. Country club membership or dues;

30. Leased or purchased vehicles; or

31. Items purchased prior to the approved PCP.

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 Waiver program service must be documented in the participant's PCP and authorized by the DDA or its designee in accordance with applicable policy.

I. The goods and services must provide or direct an exclusive benefit to the participant.

J. 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).

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

L. 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.

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, 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.

N. 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 avoiding institutionalization.

O. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the FMCS.

P. 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. The one exception is for the Day-to-Day Administrative Support where a relative can provide the support if selected by the person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is no limit on the amount an individual may expend on goods and services from their annual individualized budget so long as the totality of services purchased through the annual individualized budget addresses the needs identified in the individual's PCP. However, expenditures for any specific goods or services in excess of $5000 require prior authorization by the DDA to ensure the goods/service meets the criteria stipulated in service specification, alignment with the PCP, and to ensure that the purchase represents the most cost-effective means of meeting the identified need.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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	Entity – for participants self-directing services

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:

Individual

Provider Type:

Entity – for participants self-directing services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Based on the service, equipment or supplies vendors may include:

1. Commercial business

2. Community organization

3. Licensed professional

Verification of Provider Qualifications

Entity Responsible for Verification:

FMCS provider, as described in Appendix E.

Frequency of Verification:

FMCS provider - Prior to purchase.

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 Â§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):*

SERVICE DEFINITION

A. Nursing Support Services provides a registered nurse, licensed in the State of Maryland, to perform Nursing Consultation, Health Case Management, and Delegation services, based on the participant's assessed need.

B. At a minimum, the registered nurse 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 performance of nursing tasks, including administration of medication;

b. The participant's nursing tasks are delegable in accordance with the MBON's regulations; and

c. The participant's nursing tasks 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, for the participant and the participant's uncompensated caregivers for use in training the participant's direct support staff; and

3. Develop or review communication systems 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 registered nurse 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 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 protocols developed.

E. Health Case Management services, as provided in Section D above, does not include delegation of nursing tasks 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 registered nurse 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 health care plans and 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 health care plans and protocols developed;

4. Monitor 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 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. Ensure available on a 24/7 basis, or provide qualified back-up, 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 to a participant.

SERVICE REQUIREMENTS:

A. The DDA will authorize the amount, duration, and types of services under this 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's health needs require performance of nursing tasks, including administration of medication;

b. The participant is enrolled in the self-directed services delivery model;

c. The participant receives a Waiver program service for which the participant has employer authority, as provided in Appendix E;

d. 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 Waiver program service; and

e. The participant's health needs are exempt from delegation of nursing tasks 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 nursing tasks, including administration of medication;

b. The participant either:

i. Is enrolled in the traditional services delivery model; or

ii. Is enrolled in the self-directed services delivery model and receives a Waiver program service for which the participant does not have employer authority, as provided in Appendix E;

c. 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 Waiver program service; and

d. The participant's health needs are exempt from delegation of nursing tasks 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;

b. The participant is enrolled in either service delivery model;

c. Direct support staff provide the participant with a Waiver program service, whether employed by, or contracted with, a provider or the participant;

d. During provision of that Waiver program service, the direct support staff needs to perform nursing tasks for the participant to maintain the participant's health and safety;

e. The nursing tasks are delegable to the direct support staff in accordance with applicable 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 nursing tasks or administration of any medication;

b. The nursing tasks are not delegable in accordance with applicable Maryland regulations; or

c. The participant does not have any direct support staff paid, to provide any Waiver program service either under the traditional services delivery model or self-directed services delivery model, or any uncompensated caregivers.

C. The registered nurse must complete and maintain documentation of delivery of these 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 registered nurse must comply with all applicable laws, regulations, and Department policies governing delivery of these Waiver program services, including but not limited MBON's regulations, and the standards of nursing care. If there is a conflict between this 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, 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.

F. A participant cannot qualify, or receive funding from the Waiver program, for this 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 avoiding institutionalization.

***SERVICE DEFINITION CONTINUED BELOW DUE TO SPACE LIMITATIONS

e. The participant's health needs are exempt from delegation of nursing tasks 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 nursing tasks, including administration of medication;

b. The participant either:

i. Is enrolled in the traditional services delivery model; or

ii. Is enrolled in the self-directed services delivery model and receives a Waiver program service for which the participant does not have employer authority, as provided in Appendix E;

c. 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 Waiver program service; and

d. The participant's health needs are exempt from delegation of nursing tasks 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;

b. The participant is enrolled in either service delivery model;

c. Direct support staff provide the participant with a Waiver program service, whether employed by, or contracted with, a provider or the participant;

d. During provision of that Waiver program service, the direct support staff needs to perform nursing tasks for the participant to maintain the participant's health and safety;

e. The nursing tasks are delegable to the direct support staff in accordance with applicable 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 nursing tasks or administration of any medication;

b. The nursing tasks are not delegable in accordance with applicable Maryland regulations; or

c. The participant does not have any direct support staff paid, to provide any Waiver program service either under the traditional services delivery model or self-directed services delivery model, or any uncompensated caregivers.

C. The registered nurse must complete and maintain documentation of delivery of these 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 registered nurse must comply with all applicable laws, regulations, and Department policies governing delivery of these Waiver program services, including but not limited MBON's regulations, and the standards of nursing care. If there is a conflict between this 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, 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.

F. A participant cannot qualify, or receive funding from the Waiver program, for this 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 avoiding institutionalization.

***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

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. Supports provided by this Waiver service is 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 Waiver program, either directly or indirectly, to provide this 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.

J. For participants enrolled in the self-directed services delivery model, 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 service 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.

3. Cost for training, mileage, benefits, and leave time are allocated from the participant's total budget allocation.

****

***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 up to a 4-hour period within a 3-month period.

2. Nurse Health Case Management services are limited up to a 4-hour period within a 3-month period.

3. Nurse Delegation – The frequency of assessment is minimally every 45 days, but may be more frequent based on the MBON 10.27.11 regulation and the prudent nursing judgment of the delegating RN in meeting conditions for delegation. This is a person-centered assessment and evaluation by the RN that determines duration and frequency of each assessment.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Registered Nurse
Agency	Nursing Services Provider

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:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse License

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Possess a valid Maryland and/or Compact Registered Nurse License;

2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation training within 90 days of first providing services;

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. 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. Have Commercial General Liability Insurance;

12. 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 provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;

15. Demonstrate financial integrity through IRS, Department, 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.

Individuals providing services for participants self-directing their services must meet the standards 1 through 9 noted above. They do not need to submit a DDA provider application. Individuals must submit forms and documentation as required by the FMCS agency. The FMCS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of certified Registered Nurses.

2. FMCS provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS – 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:

Agency

Provider Type:

Nursing Services 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. 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 agencies 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 MDAT;

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 and per DDA policy;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. 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. 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 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 that spend any time alone with a participant must meet the following minimum standards:

1. Possess valid Maryland and/or Compact Registered Nurse License;

2. Successful completion of the DDA RN CM/DN Orientation training within 90 days of first providing services.

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. 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. Complete required orientation and training designated by DDA; and

12. Complete necessary pre/in-service training based on the PCP.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers.

2. Nursing Service Agency for verification of staff member's licenses, certifications, and training.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. Nursing 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 Â§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:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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. Enrollment 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.

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 PCP.

C. 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 must 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.

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 avoiding institutionalization.

F. A legally responsible individual legal guardian or a relative of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

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 year.

2. The amount of training or registration fees for registrations costs at specific training events, workshops, seminars, or conferences is limited to $500 per participant per year.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Participant Support Professional
Agency	Participant Education, Training and Advocacy Supports Agency

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:

Individual

Provider Type:

Participant Support 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. Have a Bachelor's Degree, professional license, certification by a nationally recognized program, or demonstrated life experiences and skills to provide the service;

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;

5. Complete required orientation and training designated by DDA;

6. 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 values in Annotated Code of Maryland, Health General, Title 7;

8. Demonstrate financial integrity through the IRS, Department, 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.

Individuals providing services for participants self-directing their services must meet the standards 1 through 4 noted above. They do not need to complete the DDA provider application. Individuals must submit forms and documentation as required by the FMCS agency. FMCS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of certified Participant Support Professional.

2. FMCS provider as described in Appendix E, for participants 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: 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 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 with 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. 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 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.

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 a Bachelor's Degree, professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;

3. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

4. Complete necessary pre/in-service training based on the PCP;

5. Complete required orientation and training designated by the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Participant Education, Training and Advocacy Supports Agency.

2. Provider for verification of staff standards.

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: 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 Â§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:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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 PCP.

B. For purposes of this 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 non-traditional Transportation providers;

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 Waiver program, either directly or indirectly, to provide this 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 Personal Supports beginning July1, 2020 or Respite Care.

G. 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.

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 avoiding institutionalization.

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**

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	Transportation Professional or Vendor

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 certified or licensed by the DDA 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 employs and have a copy of the same available upon request.

2. Obtain Workers' Compensation if required by law.

The OHCDS and FMCS 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 complete pre/in-service training.

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. ESPA;

B. APTA;

C. CTAA;

D. NTI;

E. ACB;

F. National Federation of the Blind;

G. ATI;

H. DORS approved vendors/contractor; or

I. Other recognized entities based on approval from the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the OHCDS.

2. OHCDS System provider and FMCS for verification of staff qualifications.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. OHCDS and FMCS – 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: Transportation

Provider Category:

Individual

Provider Type:

Transportation Professional or Vendor

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. 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. Complete required orientation and training designated by the DDA;

7. 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 values in Annotated Code of Maryland, Health General, Title 7;

9. Demonstrate financial integrity through the IRS, Department, and Medicaid Exclusion List checks;

10. Have a signed DDA Provider Agreement for Conditions for Participation; 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. DDA for approval of certified Transportation Professional and Vendors.

2. FMCS providers, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA - Initially and at least every 3 years.

2. FMCS providers – Prior to delivery of 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 Â§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 the DORS.

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, 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.

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 avoiding institutionalization.

L. 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.

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.

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 avoiding institutionalization.

L. 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:

Vehicle Modifications payment rates for services must be customary, reasonable according to current market values, and may not exceed a total of $15,000 within a ten-year period.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 certified or licensed by the DDA to provide at least one Medicaid waiver service; and

2. Complete the DDA provider application to be an OHCDS provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs 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. DDA for approval of certified Vehicle Modification Vendor.

2. FMCS provider, as described in Appendix E, for participants self-directing services.

Frequency of Verification:

1. DDA – Initially and at least every 3 years.

2. FMCS - 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 DDA provider application and be certified 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. Complete required orientation and training designated by the DDA; For driving assessments, complete person specific pre/in-service training to be aware of the participants communication preferences, sensitivities, and health or behavior strategies so they can adapt training as needed.

4. 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;

5. Demonstrate financial integrity through the IRS, Department, and Medicaid Exclusion List checks;

6. Have a signed DDA Provider Agreement for Conditions for Participation; and

7. 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 provide a statement to meet the individual's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the OHCDS.

2. OHCDS providers for verification of entities and individuals they contract or employ.

Frequency of Verification:

1. DDA – 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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participant as per COMAR 10.09.48 as an administrative service.

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 specific providers have criminal background checks prior to services 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.

The DDA-licensed and certified provider must complete this requirement for all of the provider's employees and contractors hired to provide direct care. 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 COMAR Title 12, Subtitle 15. COMAR 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 providing services under the Self-Directed Services delivery model.

CPS 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. Staff engaging in one-to-one interactions with children under the age of 18 must have a CPS Background Clearance.

State Oversight of Compliance with These Requirements

The DDA, OLTSS, and OHCQ review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations. Annually the DDA will review FMCS 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; and, (c) the process for ensuring that mandatory screenings have been

conducted. 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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.*

DEFINITIONS:

Extraordinary Care

Extraordinary care means care exceeding the range of activities that a legally responsible individual 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 a natural or adoptive parent, step-parent, child, stepchild, or sibling, who is not also a legal guardian or legally responsible person.

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.

(a) SERVICES THAT MAY BE PROVIDED BY LEGALLY RESPONSIBLE PERSONS
The State makes payment to a legally responsible individual, who is appropriately qualified, for providing extraordinary care for the following services:
1. Community Development Services
2. Personal Supports
A legally responsible person may not be paid to provide these Waiver program services if it does not constitute extraordinary care as defined above.

(b) CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

Participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Service Delivery Model may use their legally responsible person to provide services in the following circumstances, as documented in the participant's PCP:

1. The proposed provider is the choice of the participant, which is supported by the team;
2. There is a lack of qualified providers to meet the participants needs;
3. 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;
4. The legally responsible person provides no more than 40-hours per week of the service that the DDA approves the legally responsible person to provide; and
5. The legally responsible person has the unique ability to meet the needs of the participant (e.g., has special skills or training, like nursing license).

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 direct care services.

(c) SAFEGUARDS
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 PCP by the CCS:
1. Choice of the legally responsible person to provide Waiver services truly reflects the participant'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 services by the legally responsible person is appropriate and based on the participant's identified support needs;
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 PCP 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 be no longer be available;
6. A Self Directed Services Participant 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 he or she will implement the PCP 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 SDS 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.

(d) STATE'S OVERSIGHT PROCEDURES
The DDA 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.

☒ **Self-directed**

☒ **Agency-operated**

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.*

DEFINITIONS

Relative

For purposes of this Waiver, a relative is defined as a natural or adopted parent, step-parent, child, stepchild or sibling who is not also a legal guardian or legally responsible person.

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 Traditional Services Delivery Model may use a legal guardian (who is not a spouse), who is appropriately qualified, to provide :
1. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support;
2. Nursing Support Services;
3. Participant Education, Training and Advocacy Supports;
4. Personal Supports;
5. Respite Care Services;
6. Support Broker; and
7. Transportation.

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Services Delivery Model may use a relative (who is not a spouse), who is appropriately qualified, to provide:
1. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support;
2. Nursing Support Services;
3. Participant Education, Training and Advocacy Supports;
4. Personal Supports;
5. Respite Care Services;
6. Support Broker; and
7. Transportation.

The legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's PCP:
1. The proposed individual is the choice of the participant, which is supported by the team;
2. Lack of qualified provider to meet the participant's needs;
3. 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;
4. The legal guardian or relative provides no more than 40- hours per week of the service that the DDA approves the legally responsible person to provide; and
5. The legal guardian or relative has the unique ability to meet the needs of the participant (e.g., has special skills or training like nursing license).

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.

SERVICES FOR WHICH PAYMENT MAY BE MADE

As specified in Appendix C-1/C-3 and this Appendix C-2-e, a legal guardian may be paid to furnish the following services :
1. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support;
2. Nursing Support Services;
3. Participant Education, Training and Advocacy Supports;
4. Personal Supports;
5. Respite Care Services;
6. Support Broker; and
7. Transportation.

As specified in Appendix C-1/C-3 and this Appendix C-2-e, a relative may be paid to furnish the following services :
1. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support;
2. Nursing Support Services;
3. Participant Education, Training and Advocacy Supports;
4. Personal Supports;
5. Respite Care Services;
6. Support Broker; and
7. Transportation.

Safeguards

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 PCP:
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 services by the legal guardian or relative is appropriate and based on the participant's identified support needs;
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 PCP 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 be 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 implement the PCP 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 service 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.

STATE'S OVERSIGHT PROCEDURES

Annually, the DDA 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 DDA Policy - Application and Approval Processes for Qualified Supports/Services Providers in DDA's Waivers. This policy:
a) Describes specific requirements for completion and submission of initial and renewal applications for prospective providers seeking DDA approval to render supports, services and/or goods under DDA's Waivers,
b) Provides definition and eligibility requirements for qualified service professionals regarding each support or service rendered under each support Waiver, 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.

Once an applicant submits their application, the policy requires that upon receipt of an application, the applicable DDA rater review it within 30 days and an approval or disapproval 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 which is an attachment for the policy.

3. Instructions for Completing the Provider Application - Interested applicants may download or request a hard copy from the DDA Regional Office the following:
a) DDA Application to Render Supports and Services in DDA's Waivers;
b) DDA Application to Provide Behavioral Supports and Services; and
c) 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 certified by the DDA as a qualified service provider in the supports Waivers;

4. Provider Checklist Form – A checklist form which applicants must use to ensure that they have included all required information in their applications; and

5. Frequently Anticipated Questions (FAQs) and Answers - A document which provides quick access to general applicant information.
Interested community agencies and other providers can submit the DDA 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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-PM1 # and % of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision. Numerator = # of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision. Denominator = # of newly enrolled Community Pathways Waiver licensed provider reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review, DDA Provider Services, and/or QIO

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: OHCQ, 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-PM2 # and% of providers who continue to meet required licensure and initial QP standards. Numerator = # of providers who continue to meet required licensure and initial QP standards. Denominator = Total # of enrolled Waiver enrolled licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ, New Applicant Tracking Sheet Record Review DDA Provider Services, and/or QIO

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: OHCQ, 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):*
	☐ **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-PM3 # and % of newly enrolled certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. Numerator = # of newly enrolled certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. Denominator= # of newly enrolled certified waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Renewal Application Packet

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-PM4 # and % of certified waiver providers that continue to meet regulatory and applicable waiver standards. Numerator = # of certified waiver providers that continue to meet regulatory and applicable waiver standards. Denominator= # of

enrolled certified waiver providers reviewed.

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

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **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-PM5 # and % of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Numerator = # of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Denominator = # of enrolled licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review, DDA Provider Services, QIO

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: OHCQ, 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-PM6 # and % of certified waiver providers who meet training requirements in accordance with the approved waiver. Numerator = # of certified waiver providers who meet training requirements in accordance with the approved waiver. Denominator = # of enrolled certified waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certified Provider Data, Provider Services, QIO

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**
	☐ **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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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.

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**	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify: QIO	
	☐ **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.

To improve compliance with the Qualified Provider performance measures, the below quality improvement activities will be implemented.

1. Measure: DDA Licensed Providers continue to meet required licensure and standards:

a. The DDA's Provider Services staff will notify providers via email at least 90 days prior to the DDA license approval expiration date to submit the renewal application. 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 new provider self-assessment tool 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 OHCQ, 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 will collect training attestations for each provider quarterly.
b. DDA's Provider Services team will statistical random sample in each region 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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Family Supports Waiver services include various support 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 §441.301(c)(4). 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(c)(4) and includes specific provider requirements.

The following service is provided at licensed sites which must comply with the HCB settings requirement prior to enrollment as a waiver service provider:

Respite Care Services can be provided in the participant's home, a community setting, a Youth Camp certified by MDH, or a site licensed by the Developmental Disabilities Administration.

There are no residential services provided.

All new providers must comply with the HCB 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 HCB settings requirements.

Each site is assessed for HCB 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 CFR 441.301(c)(2)(xiii).

Ongoing assessment is part of the annual person-centered service planning and provider performance reviews. CCS assesses participants' service settings for compliance with HCB settings requirements and completes a Community Setting Questionnaires (CSQ). Each CSQ must demonstrate that the program provider meets the HCB setting requirements annually and each time a placement changes.

DDA reviews CSQ's flagged as potentially not meeting standards. DDA follows up with the CCS and provider agency and remediate as applicable. DDA actions may include conducting an on site assessment and issuing corrective action as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

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 *(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 certifies and contracts with provider organizations, which provide appropriately qualified staff, known as CCS, to provide case management services to participants through the Medicaid State Plan TCM 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 COMAR 10.09.48.05 and 10.22.09.06, respectively, as amended.

As provided in Medicaid's TCM regulations, CCS education and experience requirements may be waived if an individual has been employed by a DDA-certified Coordination of Community Service agency as a CCS for at least 1 year as of January 1, 2014.

Ineligibility for Employment

As provided in Medicaid's TCM regulations, 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 provider organization and entity;

2. Is on the Maryland Medicaid exclusion list;

3. Is on the federal List of Excluded Individuals/Entities (LEIE);

4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);

5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;

6. 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

7. 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

Each CCS must possess the skills necessary to:

1. Coordinate and facilitate planning meetings;

2. Create PCPs;

3. Negotiate and resolve conflicts;

4. Assist participants in gaining access to services and supports; and

5. Coordinate services and monitor the quality and provision of services.

Required Staff Training

All DDA-certified Coordination of Community Service providers shall ensure and document that each CCS staff member receives any training required by the DDA including person-directed and person-centered supports focusing on goals and outcomes.

☐ **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. *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.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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, their legal guardian or authorized representative(s) (if applicable), and their family members (if appropriately authorized by the participant), 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.

(b) The CCS provides each participant, their legal guardian or authorized representative(s) (if applicable), and their family members (if appropriately authorized by the participant) with information about the participant’s rights to determine their person-centered planning team. The participant, or their legal guardian or authorized representative(s) (if applicable) acting on the participant’s behalf, may 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, or their legal guardian or authorized representative(s) (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. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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, their legal guardian or authorized representative(s) (if applicable), and their chosen team. The participant, along with their legal guardian or authorized representative (if applicable) is 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, their legal guardian or authorized representative(s) (if applicable) and chosen family members are the central members of the team responsible for planning and developing a PCP. As further specified in subsection d. above, the participant, their legal guardian or authorized representative(s) (if applicable), and chosen family members are the central members of the team responsible for planning and developing a Person-Centered Plan. The participant, and their legal guardian or authorized representative(s) (if 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, or their legal guardian or authorized representative(s) (if applicable), also retain the authority to exclude any participant from development of their PCP with the CCS. The participant, or their legal guardian (if applicable), indicate their agreement with the PCP by signing a Signature page that can be in writing or via electronic means.

Participants may also seek support with decision making from a specific person or a team of 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 Waiver program application process and updated annually, or more frequently when there are changes to the participant’s circumstances or services.

The CCS contacts the participant, and their legal guardian or authorized representative(s) (if 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, 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 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 require.

In addition to these assessments, the CCS gathers information regarding the participant needs, outcomes, and preferences from the participant, their family, friends, and any other participants 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 legal guardian, or authorized representative(s) (if applicable) about available Waiver program services, as well as 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, via the internet, a comprehensive list of DDA services (including all Waiver program covered services) and DDA providers. The CCS assists the participant in integrating the delivery of supports needed. If the participant does not have internet access, the CCS provides the participant with a hard-copy resource manual.

(d) How Development Process Ensures Plan Addresses the Participant’s Goals, Needs, and Preferences

The DDA requires each CCS 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, their legal guardian, or authorized representative(s) (if applicable), their circle of support (family and friends), assessments, observations, and interviews.

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 in order for them to 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 Waiver program. Skills to be developed or maintained under 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, their legal guardian or authorized representative(s) (if applicable) family member(s), and provider or direct care staff in implementing the PCP.

During the transition period to LTSSMaryland, the PCP detailed service authorization section will identify Waiver program services in LTSSMaryland that meet the participant's goals, needs, and preferences. Once those services are selected, the Cost Detail Tool is completed for providers that have not transitioned to LTSSMaryland billing. The Cost Detail Tool lists the comparable legacy services that are available through PCIS2, including amount, duration, and scope for the PCP plan year. For new participants with no service provider selected, the CCS completes the Cost Detail Tool. For participants with selected providers, the provider completes the Cost Detail Tool and submits it to the CCS. After the CCS reviews and confirms with the participant that the Cost Detail Tool meets their needs and preferences, they upload it in the PCP documentation section so that it is included with the PCP for submission to the Regional Office through LTSSMaryland.

(e) How Waiver and Other Services are Coordinated

The CCS assists the participant and the team in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and 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 those things that are important To and For them and identifies their needs, goals, interests, and preferences related to achieving their desired 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, 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, finance, home and housing, health and wellness, and relationships goals.

(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 CCS is responsible for monitoring implementation of the PCP on an ongoing basis and, at a minimum, quarterly basis through telephone, e-mail, and face-to-face contacts. The CCS monitors that the services and supports meet the participant's health and safety needs. In addition, when a change in health status occurs, 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, their legal guardian, or authorized representative(s) (if 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.

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 unnecessary 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 require 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 Registered Nurse 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 interviews and record reviews 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 revises as necessary, 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, which are incorporated into the PCP and service record.

Once identified, the CCS will incorporate individualized risk mitigation strategies, including back–up 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 DDA-licensed and certified service providers must have a system for providing emergency back-up services and supports as part of their 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, their legal guardian or authorized representative, and other identified planning team members regarding available Waiver program services, service delivery models (i.e., SDS and Traditional Service Delivery Model), and 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.

For participants choosing the SDS Delivery Model, the CCS informs the participant of their options under the employer authority to identify and select their staff and service providers.

For participants choosing the Traditional Services delivery model, the CCS informs the participant of available DDA-licensed and certified 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 OLTSS ensures compliant performance of this waiver by delegating specific responsibilities to the Operating Agency (the DDA) through an Interagency Agreement (IA).

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 assure 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 as per policy and guidance. PCPs are also reviewed during DDA site visits, QIO, and OHCQ surveys to ensure they are current and comply with all Waiver eligibility, fiscal and programmatic regulations.

The PCPs are maintained in the Maryland's Long-Term Services and Supports (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 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(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 exploration and discovery of important relationships, community connections, faith-based associations, health needs, areas of interest, and talents that can also help to 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). Supports identified are then noted with the Support Considerations chart that include the name of the person, relationship, support/service, and support role.

In addition, Community Living–Group Home and Community Living–Enhanced Support services are delivered by provider owned 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.

(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 an enhanced LTSSMaryland-based 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 encourages 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 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 and authorized PCP. It also ensures that the participant has access to services, has a current back-up 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 various means including telephone conferences, emails, virtual meetings, and face-to-face meetings with the participant, their legal guardian or authorized representative (if applicable), and other identified planning team members, and service providers. The CCS is required to conduct a face-to-face visit with the participant enrolled in services at least once per quarter.

The CCS must enter into LTSSMaryland, on a standardized form required by the DDA, information regarding these monitoring activities and follow-up actions. Health and safety concerns must be reported directly to the DDA via communication with the DDA Regional Office and/or incident reporting as per required by the PORII.

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, CCS required quarterly monitoring and follow up forms are automated in the LTSSMaryland system. The DDA has implemented a CCS squad within each Regional Office who are responsible for providing technical assistance and oversight to CCS agencies. Most recently the DDA has also contracted with a Quality Improvement Organization to facilitate CCS billing audits and quality assurance reviews of PCP's and monitoring/follow up. These audits and quality assurance reviews will result in a Plan of Correction (POC), as applicable. The DDA Regional Offices will ensure any POC is completed and satisfied.

The LTSSMaryland Monitoring Form Report provides both the DDA and CCS agencies information related to review 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 agency to review applicable data related to completion and timely submission of PCP's and Monitoring/Follow up. The Regional Offices are tracking and monitoring PCP completion on a weekly basis and following up with applicable CCS agencies as necessary.

Each CCS will review evidence of satisfaction with support, health and safety needs, and service goal implementation and document whether progress has been made for people on their caseload. They will also review necessary documentation to verify the provision of services as authorized. If there is insufficient progress, the CCS will follow-up with the service provider to determine why progress is not being made.

The additional the QIO and DDA Regional Office staff will also review a sample of the quarterly monitoring forms and a reliability check will be completed during a provider visit to ensure that the documentation accurately reflects plan implementation. Applicable follow up with CCS will occur as necessary.

Based on the DDA’s monitoring activities, action is taken on all immediate jeopardy findings and technical assistance, training, and/or POCs are initiated.

The CCS is required to perform face-to-face monitoring and follow-up activities, at a minimum, quarterly basis or more frequently as needed. This monitoring must take place in the different service delivery settings.

The 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; and (e) Technical Assistance; and (f) service request review; and

3. Regional Offices and QIO monitoring the quality of the CCS monitoring of PCP implementation as outlined in the monitoring policy.

b. Monitoring Safeguards. *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.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 participantsâ 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 - # and % of waiver participants who have their assessed needs and goals addressed in the service plan using waiver funded services or other means.
Numerator = # of waiver participants who have their assessed needs and goals addressed in the service plan using waiver funded services or other means.
Denominator = # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or Quality Improvement Organization (QIO)

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: Quality Improvement Organization (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:
SP – PM2 - # and % of waiver participants who have their personal outcomes addressed in the service plan through waiver funded services or other funding sources or natural supports. Numerator = # of waiver participants who have their personal outcomes addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator = # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or Quality Improvement Organization (QIO)

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: Quality Improvement Organization (QIO)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***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 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	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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: N/A
	☒ **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:	☐ **Annually**

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participantâs needs.***

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 – PM3 - # and % of service plans reviewed and updated before the waiver participant’s annual review date. Numerator = # of service plans reviewed and updated before the waiver participant’s annual review date. Denominator = # of waiver participant reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or Quality Improvement Organization (QIO).

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: Quality Improvement Organization (QIO)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***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 – PM4 - # and % of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the PCP. Numerator = # of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the PCP. Denominator = # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, and/or QIO

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**
	☐ **Other** Specify:

e. ***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 – PM5 – # and % of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator = # waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Denominator = Total # of records reviewed.

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

Participant Record Review, and/or Quality Improvement Organization (QIO)

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: 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:	☐ **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:

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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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 CCS providers and provides specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used, including additional communication with, and training to provider. Remediation efforts will be documented in the provider's file with the DDA.

The DDA and the CCS providers report issues with LTSSMaryland functionality to a centralized help desk. The DDA, the OLTSS, and LTSSMaryland consultants meet weekly to review and prioritize system-related issues.

To improve compliance with the performance measure, the QIO 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 QIO 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).

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Other** Specify: Quality Improvement Organization (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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

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.

he DDA has established a service delivery model in which a participant or their legal guardian (as applicable) may direct their own services or designate an authorized representative to direct on their behalf. This model is known as the SDS Model. The DDA offers the SDS Model for participants, along with their team, their legal guardian, or designated representative (as applicable), be 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 under the SDS Model

Under the SDS Model, a participant or their legal guardian, (as applicable) has decision–making authority as the employer of record, including Employer and Budget Authorities. They have direct responsibility for management of their services and meeting program requirements. Participants may also seek support with decision making from a specific person or a team of 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.

This includes the rights and obligations of an employer under applicable federal, State, and local law and regulations. In addition, the participant, along with their team, their legal guardian, or designated representative (as applicable) will have the responsibility and authority over how funds in a budget are spent within the total approved annual budget. With budget authority participants they have choice and control over needed LTSS and help to maintain and improve the participant's health and quality of life in their community.

In the SDS Model, the participant, legal guardian, or designated representative, with the support of their person-centered planning team, will have opportunities to:

1. Identify goals to support a trajectory for a good life in consideration of PCP 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 PCP 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. Set wages (within a reasonable and customary range and the DDA-approved annual budget).

4. Choose, recruit, train, hire, schedule, supervise, and discharge employees and vendors that furnish their services;

5. Identify needed supports and services to include in their PCP in accordance with their approved annual budget;

6. Control and manage a budget annually for the purchase of services and supports, as specified in their PCP;

7. Use a Support Broker as an optional service to assist with all aspects of self-direction 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 an administrative assistant; and

8. Use FMCS provider to assist with budget and payment responsibilities, which is required for participation in the SDS Model.

(b) How Participants May Enroll in the SDS Model

The DDA, Advocacy Specialists, and CCS will provide information about the SDS Model to all participants and their families, legal guardian, or designated representatives (as applicable). If the participant is interested in the SDS Model as the service delivery model for services, then they will work with their CCS, along with a SB, as applicable, to organize their PCP team, develop a PCP and request enrollment in the SDS Model.

The CCS and SB, 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 SDS Participant Agreement Form.

(c) Support by Entities for Participants in the SDS Model

The following entities will provide support services to participants in the SDS Model: the CCS, the DDA Regional Office SDS Leads, Advocacy Specialists, SBs, and the FMCS provider.

The CCS 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 what service design and delivery models (SDS and Traditional) will work best for the participant and their support network in accordance with their needs and goals;

2. Providing information related to Waiver program services available under the SDS model, including SB and FMCS provider services, and providers/vendor options for the participant to choose;

3. Explaining roles and responsibilities of the participant, SB and the FMCS agency, employer and budget authorities' responsibilities, and the participant agreement pertaining to the types of available supports within the SDS Model;

4. Facilitating the timely development and revision of the PCP and SDS 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 RO SDS Leads

1. The DDA RO SDS 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 waiver requirements and the rights/responsibilities of self-direction;

b. Clarification requests of PCP and documents; and

c. Meeting with teams to address requests that do not meet waiver requirements or show assessed need.

3. The RO SDS Lead can also support participants and teams to mitigate conflicts of interest by providing feedback to the annual Participant Agreement and other PCP documents.

Advocacy Specialists provide informational supports for participants considering or enrolled in the SDS, 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 SDS Model;

4. Providing general support to participants enrolled in SDS Model; and

5. Developing and conducting additional topic specific training that meets the needs of SDS participants in their regions, such as abuse, neglect, exploitation, and nepotism.

A SB works at the direction of and for the benefit of a participant who uses SDS with:

1. Making informed decisions in arranging for, directing, and managing services the participant receives, including decisions related to personnel requirements and resources needed to meet the requirements;

2. Accessing and managing identified supports and services for the participant; and

3. Performing other tasks as assigned by the individual and as authorized by regulations adopted or guidance issued by the Federal Centers for Medicare and Medicaid Services under Section 1915(c) of the Social Security Act.

SBs can also assist with budget authority responsibilities and working with vendors. All duties for which the SB will provide assistance should be noted on the Participant Agreement form and Service Implementation Plan. SBs can assist the participant, along with their designated representative, with any task associated with SDS.

SB services are offered as an optional service to all participants who enroll in the SDS Model, and as required service if the participant employs a relative, designated representative, legal guardian or day to day administrative assistant that is a direct support employee. If a SB 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 SB 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 SB.
SBs 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.

SB 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, an SB may assist a participant during the development of a PCP to ensure that the participant's needs and preferences are clearly understood even though a CCS 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 PCP and record should clearly delineate responsibilities for the performance of activities.

SB services can also assist participants, along with their team, legal guardians, or their designated representatives (as applicable) with the 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.

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 SDS 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.

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 CCS is responsible for providing information to the participant and their legal guardian, or designated representative (as applicable) about available Waiver program services and delivery models, including the DDA's Traditional and SDS Models. The CCS provides information on availability of services, benefits, responsibilities, and liabilities associated with participation in the SDS Model. The CCS provides this information during the initial meeting, the annual Person-Centered Planning Meeting, and upon request. The CCS will document the participant's service delivery model choice on the initial Freedom of Choice Form. In addition, the CCS will attest to informing the participant of their right to choose the service delivery model (either the SDS Model or Traditional/Provider Model) on the PCP signature sheet. The participant and their authorized representative also attest that they understand the participant is free to choose the service delivery model (either the SDS Model or Traditional/Provider Model) on the PCP signature sheet.

The DDA also provides information about its SDS Model via webinars, workshops, conferences, the DDA's website, and upon request.

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:

A participant enrolled in the SDS 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 SDS Participant Agreement. The SDS Participant's Agreement 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 the Agreement.

Requirements of the Agreement include:

1. The participant's CCS must assist the participant and their team to complete this agreement per the participant's preferences and best interests.
2. The CCS must assist the participant and their team to update this agreement if any changes are requested by the participant or their team members.
3. The CCS must review this document with the participant on a quarterly basis to:
a. Make sure that the team members are those that the participant chooses, and
b. Confirm that each team member's agreement to assist and support the participant as stated in this document is current.
4. The CCS must make sure that the participant's team roles and responsibilities do not conflict with program requirements and rules. The roles, work, and responsibilities of each team member are different. This means that the work of one team member cannot be completed by another team member. The roles and responsibilities of each member are outlined and described or defined in the DDA SDS Handbook and applicable DDA Waiver. Those roles include:
a. Participant;
b. CCS;
c. Employee, Provider, Vendor, and Contractor;
d. FMCS provider; and
e. SB.

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
Behavioral Support Services	☐	☒
Assistive Technology and Services	☐	☒
Vehicle Modifications	☐	☒
Family Caregiver Training and Empowerment Services	☐	☒
Support Broker Services	☒	☒
Environmental Assessment	☐	☒
Family and Peer Mentoring Supports	☐	☒
Personal Supports	☒	☒
Environmental Modifications	☐	☒
Housing Support Services	☐	☒
Individual and Family Directed Goods and Services	☐	☒
Transportation	☒	☒
Respite Care Services	☒	☒
Nursing Support Services	☒	☒

Waiver Service	Employer Authority	Budget Authority
Participant Education, Training and Advocacy Supports	☒	☒

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 Maryland Department of Health 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 or vendors 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. Managing nursing access to the HRST to support participants enrolled in the SDS delivery model unless otherwise directed by the DDA.

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 FMCS provider assists the participant's legal guardian, 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, legal guardian, 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, legal guardian, or their designated representative (as applicable), State authorities, and other entities as requested.

d. The FMCS provider assists the participant, and their legal guardian, or designated representative (as applicable) with Budget Authority tasks such as:

i. 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);

ii. Maintaining a separate account for each participant's self-directed budget;

iii. Tracking and distributing a participant's funds, as approved by the DDA and in accordance with Waiver program
requirements;

iv. Ensuring that the participant stays within their budget and managing cost savings, including unallocated funds for goods and services not explicitly approved in the participant's PCP as per program requirements;

v. Processing and paying invoices for Waiver program services in accordance with the DDA's authorization; and

vi. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, the DDA, and other entities as requested.

vii. 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.

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 the 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 SDS or Traditional Services delivery models, must receive targeted case management services from a Services CCS. The CCS provides supports to the participant, along with their team, legal guardian, or designated representative (as applicable), and their families, 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 SDS Model, planning for the participant's future, and accessing needed services and supports. The CCS promotes services that are planned and delivered in a manner that are timely executed to meet the participant's needs as stated in their PCP 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
Behavioral Support Services	☐
Assistive Technology and Services	☐
Vehicle Modifications	☐
Family Caregiver Training and Empowerment Services	☐
Support Broker Services	☒
Environmental Assessment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Family and Peer Mentoring Supports	☐
Personal Supports	☐
Environmental Modifications	☐
Housing Support Services	☐
Individual and Family Directed Goods and Services	☐
Transportation	☐
Respite Care Services	☐
Nursing Support Services	☐
Participant Education, Training and Advocacy Supports	☐

☐ **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 receiving 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 legal guardian, (as applicable) may choose to terminate the participant's enrollment in the SDS Model at any time, without cause, in order to receive services under the Traditional Services delivery model, directly from a provider.

In order to terminate participation in the SDS Model and transition to the Traditional Services delivery model, the participant, or their legal guardian (as applicable), must notify the participant's CCS. The CCS will assist the participant in transitioning to the Traditional Services delivery model and selecting licensed/certified provider(s) to provide services. The CCS will work with the participant, legal guardian (as applicable), and the participant's team to 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 SDS Model, participants, along with their team, their legal guardians, or their designated representatives (as applicable) are required to comply with the requirements set forth in this Waiver program application and all applicable federal, State, and local laws, regulations, and Department policies and procedures.

The DDA has the authority to restrict the availability of services under the SDS Model or to terminate the participant's enrollment in the SDS Model if one of the following circumstances occurs:

1. The participant no longer meets eligibility criteria for the waiver;
2. The participant's PCP 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, legal guardian, or their designated representative;
3. The participant does not receive services under the SDS Model, in accordance with the participant's PCP 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 SDS Model;
5. The rights of the participant are being compromised;
6. Failure of the participant, their team, 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, legal guardian, or the participant's designated representative (as applicable) to manage funds within the DDA-approved annual budget, including expending or attempting to expend funds inconsistent with the DDA-approved annual budget.

In the event the DDA restricts or terminates the participant's enrollment in the SDS Model in accordance with this section, the DDA shall notify in writing the participant, legal guardian, or their designated representative (as applicable), their CCS, SB, and the FMCS 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 CCS shall work with the participant, 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		100
Year 2		200
Year 3		300
Year 4		325
Year 5		350

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:

☒ **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.

Effective January 1, 2021, during the initial 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 PCP detailed service authorization for participants, enrolled in either the SDS or 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 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 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 traditional 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 DDA Regional Office for review. If approved, the revised PCP and associated budget allocation is then used to create the self-directed budget sheet, which is provided to the team and FMCS.

If the DDA denies the request for a Waiver program service or reduces the approved budgeted amount, 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), with information related to expenditures and current budget balance. The participant can also ask their FMCS to provide additional access to their designated representative and their team based on their choice.

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- 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- 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 DDA 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 (MDH). The types of decisions or actions of the DDA and MDH for which there is a right to a Medicaid Fair Hearing are described in 42 CFR § 431.220; Maryland Annotated Code Health-General Article § 7-406; and COMAR 10.01.04. Specifically, an individual will have an opportunity for a Medicaid Fair Hearing if they brings a claim that:
1. Their application for eligibility for this Waiver program was denied;
2. They dispute the DDA's determination of their priority on the waiting list;
3. The DDA or MDH 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 MDH acted erroneously. See Maryland Annotated Code Health-General Article § 7-406; and COMAR 10.01.04.02.

Upon making a decision affecting an individual's receipt of services funded by the Waiver program, the MDH 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 family or their legal representative, and specifies:
1. The MDH's decision,
2. The legal and factual basis of the MDH's decision;
3. A description of how to submit additional information for reconsideration;
4. 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
5. Their right to continue to receive services pending the appeal.

The CCS and authorized representative 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 DDA'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 himself or herself or use legal counsel or appoint an Authorized Representative pursuant to COMAR 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.

Also attached to the letter is a pre-addressed Hearing Request Form that the individual can use to request a Medicaid Fair Hearing to contest the decision by the DDA.

If an individual requires assistance in pursuing a Medicaid Fair Hearing, their CCS will assist. Per DDA's policy, a CCS 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 CCS 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**

b. 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 DDA decision or action in question. A CRC is offered for any type of dispute for which an applicant or participant may request a Medicaid Fair Hearing (see Appendix F-1). A CRC 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 CRC is available per matter for which a Medicaid Fair Hearing is requested. The individual is informed that a CRC is not required prior to or as a substitute for a Medicaid Fair Hearing.

Not all issues can be resolved in the CRC 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 CRC & Requesting a CRC

All applicants/participants and their families and/or legal representatives (if applicable) are informed of the opportunity to engage in the CRC process when they receive the letter from the DDA informing them of an adverse action pertaining to the Waiver program services, for which the applicant or participant may request a Medicaid Fair Hearing, as described in Appendix F-1 above. As noted in Appendix F-1 above, the Hearing Request Form permits the individual to request a CRC in addition to a Medicaid Fair Hearing. If the applicant or participant selects it, the DDA schedules the CRC 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 CRC process and informs the applicant or participant of their opportunity to request a CRC.

The Hearing Request Form includes a box to check if the applicant or participant wants to have a CRC as well as a Medicaid Fair Hearing.

CRC Discussion

The CRC 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.

CRC Structure & Processes

The CRC typically lasts approximately 1 hour, and the overall structure of the CRC 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 CRC, 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.

CRCs are scheduled by the DDA's Operations Office. The MDH grants one 1 CRC to occur before an individual's Medicaid Fair Hearing. CRCs usually occur at a DDA Regional Office or other locations within a region. Separately, the OAH schedules Medicaid Fair Hearings based on requirements in COMAR 10.01.04. Medicaid Fair Hearings occur at the OAH locations or locations convenient for participants, per OAH 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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. 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 PORII

The DDA has established a PORII, which requires that all providers under Self-Directed Services (SDS) and Traditional Services Delivery Models to report critical events or incidents to the DDA. The PORII is incorporated into the DDA's regulations governing requirements for licensure for providers.

If a critical event or incident is governed by PORII, 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 PORII, either the DDA or the Office of Health Care Quality (OHCQ) review each reported event or incident, depending on the classification. The OHCQ is the DDA's designee within the Maryland Department of Health, responsible for conducting survey and investigative activities to monitor regulatory compliance, on the DDA's behalf, pertaining to provider licensure. The DDA, the OHCQ, and the OLTSS all have direct access to review reported events or incidents in PCIS2.

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), Adult Protective Services (APS) or Child Protective Services (CSP) (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, 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 within 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 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 an individual person. Restraints includes: 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 submit an initial report of 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 outlined in the PORII and include events such as physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment. A listing of all internally investigated incidents which occurred during the prior quarterly period for all DDA service providers is accessible through the DDA's PCIS2.

All provider staff to whom PORII applies must report internally investigated incidents within 1 working day of discovery to the provider's director or designee.

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 having

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. The Rights and Responsibilities form also explains how the participant can notify proper authorities when problems arise or the participant has complaints or concerns, including law enforcement, APS or CPS (as applicable), the CCS, the DDA, and OHCQ. After review with the CCS, the participant, or their legal representative signs the form acknowledging receipt.

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, COMAR 10.01.18 requires that DDA-licensed vocational and day services programs adopt Sexual Abuse Awareness and Prevention Training, including mandatory reporting requirement, 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.

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 upon 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 adult/child protective services 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 agency does not provide the information within a reasonable time frame (no later than 48 hours after 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 INCDENTS – 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 attributed to the provider and the quality of the provider's internal investigations. The OHCQ staff also reviews submitted AIR, 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 OHCQ does not have the authority to investigate a participant's non-licensed home environment. However, in those circumstances, the OHCQ will refer the matter to appropriate authorities such as law enforcement, and CPS or APS (as applicable).

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 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 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 dangerous conditions are not present and ongoing. If, based on review of the report, including the AIR, the DDA QE staff is unable to determine that action has been taken by the provider to protect the participant from harm, then the DDA QE staff will intervene. Depending on the circumstances, the DDA may intervene by contacting the DDA provider or conducting an on-site visit.

The DDA will also evaluate the Incident report 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 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 upon 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 assure 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 himself or herself 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 applied behavior analysis;

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 for the participant; and

c. A description of the hypothesized function of current behaviors, including their 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 BSP;

9. Specify the data to be collected to assess progress towards meeting the BSP's objectives; and

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. 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 BSP, the team and an individual, appropriately licensed under Health Occupations Article with training and experience in applied behavior analysis, shall recommend that the participant no longer needs a BSP.

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 its 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.

Method Of Detecting Unauthorized Use, Overuse Or 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 services being received.

2. The OHCQ, DDA, and OLTSS conduct unannounced visits and observations of DDA providers, including interviewing participants, gauging 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 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 Quality 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 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)*

b. 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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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)*

ii. 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).

iii. 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:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **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:

iv. 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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-PM1 # and % of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which correction actions executed or planned by appropriate entity in required timeframe. N = # of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. D = # of incidents reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Record Review, QIO

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):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-PM2 # and % of participants who received information about how to identify and report abuse, neglect, and exploitation. Numerator = # of participants who received information about reporting abuse, neglect, and exploitation. Denominator = # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review, QIO

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**
	☐ **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 # and % of incidents with investigation initiated within the required

timeframe. Numerator = # of incidents with investigation initiated within the required timeframe. Denominator = # of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review and QIO

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: OHCQ, 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**

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

Performance Measure:
HW PM 4 Number and percent of incidents with investigation completed within the required timeframe. Numerator = number of incidents with investigation completed within the required timeframe. Denominator = number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record 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: 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:
HW- PM 5 # and % of critical incidents systemic interventions implemented. Numerator = # of critical incidents systemic interventions implemented. Denominator = # of critical incidents systemic interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Systemic Intervention Review and QIO

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 6 # and % of incidents of restraint where proper procedures were followed.
Numerator = # of incidents of restraint where proper procedures were followed.
Denominator = # of incidents of restraint reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Restraint Record Review -PCIS2 and QIO

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**
	☐ **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:
Per guidance received at 2017 HCBS Conference, this is not applicable for Family Support Waivers as there are no residential services.

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: n/a
	☒ **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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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 on-going basis to the DDA providers and OHCQ to address specific remediation issues with the provider. Depending the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, 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 call, letter, in person meeting, 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. Dependent 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.

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 §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 waive. 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 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, and OHCQ review: (1) operational data; (2) results from direct observation of service delivery; and (3) findings from participant and provider interviews and surveys. The analysis of discovery data and remediation efforts are conducted on an on-going basis via the Waiver performance measures. The OLTSS, DDA, 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 Waiver program's performance information is shared with the OLTSS and the DDA Quality Advisory Council. The DDA Quality Advisory Council is composed of various stakeholders, including 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: Quality Improvement Organization (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.

To analyze the 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), and other experts to ensure that system design changes benefit participants and their families. 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 developmentally disabled individuals including employment, rights, service planning, community inclusion, choice, and health and safety.

The DDA has a contract with an entity that is certified by Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) or QIO-like entity 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; and

4. Administer the DDA's NCI.

For specific system improvements, the DDA 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 will institute additional or alternative approaches to effect positive and lasting changes.

The OLTSS monitors performance of this requirement by participating in the DDA Quality 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 quality improvement strategies (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):*

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 five years by Maryland's Comptroller's Office.

2. Office of Legislative Audits

The Maryland Office of Legislative Audits (OLA) conducts fiscal compliance audits every 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

The MDH's OIG 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 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 OIG conducts the audits every 3 years. If there have been issues in the past, the OIG may audit more frequently.

4. Utilization Review

The DDA has hired a Quality Improvement Organization (QIO) contractor to conduct post-payment utilization reviews of claims to ensure the integrity of payments made for 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 PCP Detailed Service Authorization (DSA) in LTSSMaryland. This review will apply to both traditional (agency-directed) and SDS Delivery Models.

The scope of the post-payment utilization review is limited to a statistically valid sample of participants and claims by service on a quarterly basis with a 95% +/-5% confidence interval. The number of providers audited will be based on the sample of participants selected for review. The review period will be 1 year of services.

The Contractor will conduct a remote audit of providers or FMCS 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, payroll records and receipts; and any other documentation required by the MDH. The Contractor will prepare a preliminary audit report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the PCP.

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

a) Less services provided than billed;

b) Less or more services provided than authorized in PCP (+/- >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 fifteen (15) working days from the date of the conclusion of the audit. Based on the findings, the DDA will prioritize targeted audits based on the prevalence of audit issues.

For the targeted audit, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's PCP. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the 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 reporting findings.

The major difference between the remote audits and the targeted audits is that the targeted audits 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 PCP. The interview will include the participants receiving services, their family or legal guardian, and Coordinator of Community Services, as appropriate.

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

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

The DDA Provider Services staff in the Regional Offices handle follow-up of corrective action plans, if any is required. The DDA Fiscal Unit will pursue any financial recovery owed to the State. If necessary, the DDA may also refer the matter to the MDH's OIG.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

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

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: # and % of claims that are supported by documentation that services were delivered. Numerator = # of claims reviewed that are supported by documentation. Denominator = # of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims data; participant records; QIO

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***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA – PM2: # and % of claims paid for participants who are eligible on the date the service was provided and where services were consistent with those in the service plans. Numerator = # of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. Denominator = # of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims data; PCIS2; LTSSMaryland data; QIO

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***
	☐ ***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: # and % of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = # of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = # of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims data; PCIS2; LTSSMaryland; QIO

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

PM2 - The reimbursement logic built into MMIS, PCIS2, and 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, the contractors, the DDA fiscal staff, or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into MMIS, PCIS2, and 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, the contractors, the DDA fiscal staff or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the reimbursement rate.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

PM1- # and % of claims that are supported by documentation that services were delivered.

If the DDA fiscal staff or the QIO 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 QIO, and the Department may initiate an expanded review or audit. If indicated, the DDA will work with Provider Services and/or the QIO 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.

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

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 PCIS2 staff and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, the DDA will adjust the claims accordingly and in a timely manner.

PM3- # and % of claims coded and paid for in accordance with the reimbursement methodology specified in the Waiver program application.

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 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 FPS services will vary in the WYs as the DDA transitions from a prospective payment system to a fee-for-service reimbursement model. Simultaneously the DDA will also transition from the current standalone platform, PCIS2, to the Medicaid Long Term Services and Supports system, or LTSSMaryland. Previous rates from the rate study completed November 2017 have been revised and trended forward with a 9.5% CPI adjustment and will be used for non-FPS services.

Until the billing for services transitions to LTSSMaryland, FPS services, or those services whose claims are submitted using PCIS2, will continue to use rates based on the rate methodology. PCIS2 rates will continue to be used for: The new rates for these services will not be adopted until DDA providers transition to submitting claims using LTSSMaryland.

The rate methodology can be found on page 246 of the Community Pathways Waiver Application for 1915(c) HCBS 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.

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, is the rate methodology used for non-FPS rates used in LTSSMaryland. 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. The 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. Also, 4 town halls were held to solicit public comment on the report. A detailed rate file is available upon request.

A geographical 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 BLS' wages 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 LTSS Maryland except Market Rate services, Behavioral Support Services, Environmental Assessment, and Family Peer and Mentoring Supports.

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)

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.

Nursing Support Services – The rate is based on hourly BLS wage data job code 29-1141 and includes ERE, Program Support, Training, and a G&A.

Respite Care Services (Respite 15-minute unit and Daily) - The rates are based on the BLS wage job code 39-9021 and include 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)

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.

Market Rate Services (WYs 1-5)

Assistive Technology and Services, Environmental Modifications, Respite Care Camp, Transportation, and Vehicle Modifications –

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 participant's needs. All requests are reviewed and approved by the DDA Regional Offices. The payment limit and any other limiting parameters will be programmed into MMIS and LTSSMaryland to avoid overpayment of these services. 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.

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. Self-Directed Services participants ("SDS Participants") 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 SDS Participants, the DDA post reasonable and customary wages and rates on the DDA website.

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 Maryland Department of Health's Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget.

The Maryland General Assembly mandated 4% COLA was approved for the State FY2020 – FY2026.

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 ARPA savings towards provider rates as directed by the State legislature.

In February 2022, the Maryland Department of Health 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.

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: Traditional Services Model or Self-Directed Services 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 traditional 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 Traditional Services Delivery Model

Until the billing for these services transitions 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, Nursing Services, Participant Education, Training and Advocacy Supports, daily and camp Respite Care Services, Transportation, and Vehicle Modifications will be claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into MMIS. The CMS 1500 is completed by the provider of services and submitted to the DDA for review. If the CMS 1500 is consistent with the participant's SFP based on their PCP, then the DDA submits the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these service claims electronically to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit.

Based on this review, if the services were 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 paper billing process to billing in LTSSMaryland and using EVV for Personal Supports 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.

Billings under the SDS Delivery Model

For participants enrolled in the SDS Model (as described in Appendix E), only the FMCS provider can submit claims on behalf of self-directed participants. When processing claims on behalf of these participants, the FMCS provider compares employee timesheets or invoices against the participant's PCP and annual self-directed services budget, approved by the DDA. For claims that match, the FMCS provider then submits them to MMIS. Claims that are rejected by MMIS are reviewed by the FMCS and the DDA federal billing unit. Based on this review, if the services were rendered in accordance with the 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 Waiver program services are made through the approved MMIS. The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the OLTSS through the MMIS.

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

MMIS edits are in place to validate the participant's waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid. While 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 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 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 Traditional 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 transitions 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 Traditional Services or the DDA-approved annual self-directed services budget for participants enrolled in Self-Directed Services Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by 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 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 Self-Directed Services Delivery Model (as described in Appendix E), Waiver program services are paid by the FMCS provider and then the FMCS submits the claim through 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 audits. The audit also monitors and assesses 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 audit of the FMCS provider, requesting and reviewing information, including: staff notes and logs for the participants identified in the remote audit; 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.

Under the current 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. This payment methodology will change when providers begin 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 may apply to do so as part of initial licensure, or by amending their current license, and must meet all regulatory requirements outlined in 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 FPS service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly.

b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website.

c) The 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 Program. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time.

d) An OHCDS must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. OHCDS shall enter into a subcontract with each provider 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 detailed record on the purchase of services from qualified entities or individuals, including invoices.

e) In the OHCDS application, the provider agrees to submit an aggregate annual summary, delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individual's serviced by each subcontractor. The report will be due within 60 days of the close 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) Billing for OHCDS contract services are completed by submitting an invoice and CMS 1500 Forms or by direct provider electronic submission in the MMIS system until billing transitions to LTSSMaryland. 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 review all claims submitted. The DDA will monitor and conduct oversight of the OHCDS by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***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:

☐ ***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:*

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:

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	41587.81	14627.48	56215.29	304278.06	6572.50	310850.56	254635.27
2	43058.36	15139.44	58197.80	314927.79	6802.54	321730.33	263532.53
3	44577.68	15669.32	60247.00	325950.26	7040.63	332990.89	272743.89
4	46188.86	16217.74	62406.60	337358.52	7287.05	344645.57	282238.97
5	47846.30	16785.36	64631.66	349166.07	7542.10	356708.17	292076.51

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	525	525
Year 2	525	525
Year 3	525	525
Year 4	525	525
Year 5	525	525

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 all WYs is 353 days. This is based on the average length of stay reported on the CMS 372(S) for the Community Pathways Waiver for fiscal years (FY) 2018-2019.

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 Waiver Years (WYs) 1-5 are based on analysis of CMS-372(S) reports and user enrollment in Family Support Waiver services in FY22-FY23 from LTSSMaryland PCP data. The estimated number of users for all WYs are calculated by applying the percentage of Family Support Services users for each service in the FY22-FY23 LTSSMaryland data file to the total users in the Family Support Services program to the Total Estimated Unduplicated Participants in Appendix B. The percentages are as follows: Assistive Technology and Services – 10.06%; Behavioral Assessment and Behavioral Plan – 11.59%; Behavioral Consultation – 12.5%, Brief Support Implementation – 9.15%; Environmental Assessment and Modifications – 3.96%; Family Caregiver Training and Empowerment Services - .61%; Family and Peer Mentoring Supports – 1.52%; Housing Support Services - .3%; Individual and Family Directed Goods and Services – 2.13% of estimated self-directed users only; Nursing Support Services – 21.04%; Participant Education, Training, and Advocacy Supports - .3%; Personal Supports – 71.34%; Personal Supports Enhanced Support – 15.55%; Respite Care Services Day – 7.32%; Respite Care Services – 35.37%; Respite Care Services Camp – 16.77%; Support Broker – 28.35% of estimated self-directed services users only; Transportation – 4.27%; and Vehicle Modifications – 1.52%.

Assuming the Estimated Unduplicated Participants will remain the same throughout the length of this waiver renewal (FY24 – FY28), the estimated users for each service will remain the same except for self-directed services. Estimated users for self-directed services Individual and Family Directed Goods and Services and Support Broker services are estimated to increase by 10% in WYs 2-5 based on analysis of the trend of users in the Community Pathways Waiver program choosing to self-direct their services. In WYs 1-2, we estimate users for services where the provider has not transitioned their billing from the PCIS2 system into the LTSSMaryland system. In WYs 3-5 (FY26-FY28) we estimate all users services to be billed using LTSSMaryland.

In the absence of historical service utilization data for the Family Support Waiver, the average units per user for WYs 1-5 are based on historical utilization of services in the Community Pathways Waiver from the FY2020 CMS-372(S) for all services except for Personal Supports and Personal Supports Enhanced Support. For the Personal Support services, the average units per user were calculated using the FY22 LTSSMaryland expenditure report for Personal Support expenditures and actual users. Hourly services in the PCIS2 system, Respite, Housing Support Services, and Family and Peer Mentoring services, were converted to 15-minute unit increments in LTSSMaryland beginning March 1, 2021. Since we estimate all users' services to be billed using LTSSMaryland in WYs 3-5, we estimate these services to transition from hourly billing to billing in 15-minute increments as well.

The estimated costs per unit for WYs 1-5 for services are based on the average budgeted amounts for the service for the estimated Family Support Waiver users from the FY22-FY23 LTSSMaryland budget data report and FY22 Self-Directed service budget report for enrolled participants. The Upper Pay Limit services include Assistive Technology and Services, Environmental Modifications, Family Caregiver Training and Empowerment Services, Individual and Family Directed Goods & Services (IFDGS), IFDGS Staff Recruitment and Advertising, Participant Education, Training and Advocacy Supports, Support Broker, Transportation and Vehicle Modifications. For the rate-based services, for WYs 1-5 an average yearly increase of 3.5% is forecasted for the cost of services for this waiver renewal based on the approved rates for FY2023. The 3.5% increase is the average of 2019 – 2021 Consumer Price Index (CPI) for medical care in the Washington-Baltimore region.

The Average Cost per Unit per WY 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/LTSS-Rates.aspx.

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:*

Factor D' was calculated for Waiver Years 1-5 based on the actual amount in the FY2020 CMS-372(S) report for the Community Pathways Waiver and trended forward using the average inflation rate of 3.5% from the 2019-2021 BLS CPI-U All Urban Consumers for Medical Care for Washington-Baltimore. 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 CMS 372(S) FY2020 report. The 3.5% inflation rate applied to Factor G for all Waiver Years is based on 2019-2021 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore.

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 CMS 372(S) FY2020 report. The 3.5% inflation rate applied to Factor G' for all Waiver Years is based on 20193-2021 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore.

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	
Personal Supports	
Respite Care Services	
Support Broker Services	
Assistive Technology and Services	
Behavioral Support 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	
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
Personal Supports Total:						**17994837.20**
Personal Supports	15 minutes	375	3460.00	10.86	**14090850.00**	
Personal Supports Enhanced Supports	15 minutes	82	3460.00	13.76	**3903987.20**	
Respite Care Services Total:						**2510466.90**
Respite	15 minutes	171	1400.00	7.88	**1886472.00**	
Daily	Day	38	10.00	442.33	**168085.40**	
Hourly	Hour	15	350.00	33.47	**175717.50**	
Camp	Item	88	1.00	3184.00	**280192.00**	
Support Broker Services Total:						**468456.00**
Support Broker Services	Hour	149	12.00	262.00	**468456.00**	
Assistive Technology and Services Total:						**77963.00**
Assistive Technology and Services	Item	53	1.00	1471.00	**77963.00**	
Behavioral Support Services Total:						**348817.70**
Plan	Plan	61	1.00	1558.33	**95058.13**	
Assessment	Assessment	61	1.00	1558.33	**95058.13**	
Brief Supports Implementation	15 minutes	48	48.00	18.66	**42992.64**	
Consultation	Hour	68	48.00	35.45	**115708.80**	
Environmental Assessment Total:						**9993.69**
Environmental Assessment	Assessment	21	1.00	475.89	**9993.69**	
Environmental Modifications Total:						**93513.00**
Environmental Modifications	Item	21	1.00	4453.00	**93513.00**	
Family and Peer Mentoring Supports Total:						**2415.90**
Family and Peer Mentoring Supports (15 minutes)	15 minutes	7	20.00	14.84	**2077.60**	

GRAND TOTAL:	**21833601.69**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**41587.81**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Peer Mentoring Supports (Hour)	Hour	1	5.00	67.66	338.30	
Family Caregiver Training and Empowerment Services Total:						1500.00
Family Caregiver Training and Empowerment Services	Item	3	1.00	500.00	1500.00	
Housing Support Services Total:						1366.30
Housing Support Services (15 minutes)	15 minutes	1	40.00	16.62	664.80	
Housing Support Services (Hour)	Hour	1	10.00	70.15	701.50	
Individual and Family Directed Goods and Services Total:						37310.00
Staff Recruitment and Advertising	Items & Services	37	1.00	478.00	17686.00	
Good and Services	Items & Services	11	4.00	446.00	19624.00	
Nursing Support Services Total:						166386.00
Nursing Support Services	15 minutes	110	60.00	25.21	166386.00	
Participant Education, Training and Advocacy Supports Total:						1000.00
Participant Education, Training and Advocacy Supports	Item	2	1.00	500.00	1000.00	
Transportation Total:						44616.00
Transportation	Item	22	12.00	169.00	44616.00	
Vehicle Modifications Total:						74960.00
Vehicle Modifications	Item	8	1.00	9370.00	74960.00	

GRAND TOTAL:	21833601.69
Total Estimated Unduplicated Participants:	525
Factor D (Divide total by number of participants):	41587.81
Average Length of Stay on the Waiver:	332

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*
Personal Supports Total:						***18624072.80***
Personal Supports	*15 minutes*	*375*	*3460.00*	*11.24*	***14583900.00***	
Personal Supports Enhanced Supports	*15 minutes*	*82*	*3460.00*	*14.24*	***4040172.80***	
Respite Care Services Total:						***2583923.80***
Respite	*15 minutes*	*179*	*1400.00*	*8.16*	***2044896.00***	
Daily	*Day*	*38*	*10.00*	*457.81*	***173967.80***	
Hourly	*Hour*	*7*	*350.00*	*34.64*	***84868.00***	
Camp	*Item*	*88*	*1.00*	*3184.00*	***280192.00***	
Support Broker Services Total:						***515616.00***
Support Broker Services	*Item*	*164*	*12.00*	*262.00*	***515616.00***	
Assistive Technology and Services Total:						***77963.00***
Assistive Technology and Services	*Item*	*53*	*1.00*	*1471.00*	***77963.00***	
Behavioral Support Services Total:						***361016.54***
Plan	*Plan*	*61*	*1.00*	*1612.87*	***98385.07***	
Assessment	*Assessment*	*61*	*1.00*	*1612.87*	***98385.07***	
Brief Supports Implementation	*15 minutes*	*48*	*48.00*	*19.31*	***44490.24***	
Consultation	*Hour*	*68*	*48.00*	*36.69*	***119756.16***	
Environmental Assessment Total:						***10343.55***
Environmental Assessment	*Assessment*	*21*	*1.00*	*492.55*	***10343.55***	
Environmental Modifications Total:						***93513.00***
Environmental Modifications	*Item*	*21*	*1.00*	*4453.00*	***93513.00***	
Family and Peer Mentoring Supports Total:						***2500.55***

GRAND TOTAL:	***22605639.34***
Total Estimated Unduplicated Participants:	***525***
Factor D (Divide total by number of participants):	***43058.36***
Average Length of Stay on the Waiver:	*332*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Peer Mentoring Supports (15 minutes)	15 minutes	7	20.00	15.36	2150.40	
Family and Peer Mentoring Supports (Hour)	Hour	1	5.00	70.03	350.15	
Family Caregiver Training and Empowerment Services Total:						1500.00
Family Caregiver Training and Empowerment Services	Item	3	1.00	500.00	1500.00	
Housing Support Services Total:						1414.10
Housing Support Services (15 minutes)	15 minutes	1	40.00	17.20	688.00	
Housing Support Services (Hour)	Hour	1	10.00	72.61	726.10	
Individual and Family Directed Goods and Services Total:						41006.00
Staff Recruitment and Advertising	Items & Services	41	1.00	478.00	19598.00	
Good and Services	Items & Services	12	4.00	446.00	21408.00	
Nursing Support Services Total:						172194.00
Nursing Support Services	15 minutes	110	60.00	26.09	172194.00	
Participant Education, Training and Advocacy Supports Total:						1000.00
Participant Education, Training and Advocacy Supports	Item	2	1.00	500.00	1000.00	
Transportation Total:						44616.00
Transportation	Item	22	12.00	169.00	44616.00	
Vehicle Modifications Total:						74960.00
Vehicle Modifications	Item	8	1.00	9370.00	74960.00	

GRAND TOTAL:	22605639.34
Total Estimated Unduplicated Participants:	525
Factor D (Divide total by number of participants):	43058.36
Average Length of Stay on the Waiver:	332

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
Personal Supports Total:						**19271957.80**
Personal Supports	15 minutes	375	3460.00	11.63	**15089925.00**	
Personal Supports Enhanced Supports	15 minutes	82	3460.00	14.74	**4182032.80**	
Respite Care Services Total:						**2660627.40**
Respite	15 minutes	186	1400.00	8.45	**2200380.00**	
Daily	Day	38	10.00	473.83	**180055.40**	
Hourly	Hour	0	350.00	35.85	**0.00**	
Camp	Item	88	1.00	3184.00	**280192.00**	
Support Broker Services Total:						**565920.00**
Support Broker Services	Item	180	12.00	262.00	**565920.00**	
Assistive Technology and Services Total:						**77963.00**
Assistive Technology and Services	Item	53	1.00	1471.00	**77963.00**	
Behavioral Support Services Total:						**373648.08**
Plan	Plan	61	1.00	1669.32	**101828.52**	
Assessment	Assessment	61	1.00	1669.32	**101828.52**	
Brief Supports Implementation	15 minutes	48	48.00	19.99	**46056.96**	
Consultation	15 minutes	68	48.00	37.97	**123934.08**	
Environmental Assessment Total:						**10705.59**
Environmental Assessment	Assessment	21	1.00	509.79	**10705.59**	
Environmental Modifications Total:						**93513.00**
Environmental Modifications	Item				**93513.00**	

GRAND TOTAL:	**23403280.87**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**44577.68**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		21	1.00	4453.00		
Family and Peer Mentoring Supports Total:						**2544.00**
Family and Peer Mentoring Supports (15 minutes)	15 minutes	8	20.00	15.90	**2544.00**	
Family and Peer Mentoring Supports (Hour)	Hour	0	5.00	72.48	**0.00**	
Family Caregiver Training and Empowerment Services Total:						**1500.00**
Family Caregiver Training and Empowerment Services	Item	3	1.00	500.00	**1500.00**	
Housing Support Services Total:						**1424.00**
Housing Support Services (15 minutes)	15 minutes	2	40.00	17.80	**1424.00**	
Housing Support Services (Hour)	15 minutes	0	10.00	75.15	**0.00**	
Individual and Family Directed Goods and Services Total:						**44702.00**
Staff Recruitment and Advertising	Items & Services	45	1.00	478.00	**21510.00**	
Good and Services	Items & Services	13	4.00	446.00	**23192.00**	
Nursing Support Services Total:						**178200.00**
Nursing Support Services	15 minutes	110	60.00	27.00	**178200.00**	
Participant Education, Training and Advocacy Supports Total:						**1000.00**
Participant Education, Training and Advocacy Supports	Item	2	1.00	500.00	**1000.00**	
Transportation Total:						**44616.00**
Transportation	Item	22	12.00	169.00	**44616.00**	
Vehicle Modifications Total:						**74960.00**
Vehicle Modifications	Item	8	1.00	9370.00	**74960.00**	

GRAND TOTAL:	**23403280.87**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**44577.68**
Average Length of Stay on the Waiver:	332

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
Personal Supports Total:						**19951467.20**
Personal Supports	15 minutes	375	3460.00	12.04	**15621900.00**	
Personal Supports Enhanced Supports	15 minutes	82	3460.00	15.26	**4329567.20**	
Respite Care Services Total:						**2745047.80**
Respite	15 minutes	186	1400.00	8.75	**2278500.00**	
Daily	Day	38	10.00	490.41	**186355.80**	
Hourly	Hour	0	350.00	37.10	**0.00**	
Camp	Item	88	1.00	3184.00	**280192.00**	
Support Broker Services Total:						**622512.00**
Support Broker Services	Hour	198	12.00	262.00	**622512.00**	
Assistive Technology and Services Total:						**77963.00**
Assistive Technology and Services	Item	53	1.00	1471.00	**77963.00**	
Behavioral Support Services Total:						**386730.46**
Plan	Plan	61	1.00	1727.75	**105392.75**	
Assessment	Assessment	61	1.00	1727.75	**105392.75**	
Brief Supports Implementation	15 minutes	48	48.00	20.69	**47669.76**	
Consultation	15 minutes	68	48.00	39.30	**128275.20**	
Environmental Assessment Total:						**11080.23**

GRAND TOTAL:	**24249148.89**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**46188.86**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Assessment	Assessment	21	1.00	527.63	11080.23	
Environmental Modifications Total:						93513.00
Environmental Modifications	Item	21	1.00	4453.00	93513.00	
Family and Peer Mentoring Supports Total:						2633.60
Family and Peer Mentoring Supports (15 minutes)	15 minutes	8	20.00	16.46	2633.60	
Family and Peer Mentoring Supports (Hour)	Hour	0	5.00	75.02	0.00	
Family Caregiver Training and Empowerment Services Total:						1500.00
Family Caregiver Training and Empowerment Services	Item	3	1.00	500.00	1500.00	
Housing Support Services Total:						1473.60
Housing Support Services (15 minutes)	15 minutes	2	40.00	18.42	1473.60	
Housing Support Services (Hour)	Hour	0	10.00	77.78	0.00	
Individual and Family Directed Goods and Services Total:						50182.00
Staff Recruitment and Advertising	Items & Services	49	1.00	478.00	23422.00	
Good and Services	Items & Services	15	4.00	446.00	26760.00	
Nursing Support Services Total:						184470.00
Nursing Support Services	15 minutes	110	60.00	27.95	184470.00	
Participant Education, Training and Advocacy Supports Total:						1000.00
Participant Education, Training and Advocacy Supports	Item	2	1.00	500.00	1000.00	
Transportation Total:						44616.00
Transportation	Item	22	12.00	169.00	44616.00	

GRAND TOTAL:	24249148.89
Total Estimated Unduplicated Participants:	525
Factor D (Divide total by number of participants):	46188.86
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications Total:						**74960.00**
Vehicle Modifications	Item	8	1.00	9370.00	**74960.00**	

GRAND TOTAL:	**24249148.89**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**46188.86**
Average Length of Stay on the Waiver:	332

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
Personal Supports Total:						**20646788.80**
Personal Supports	15 minutes	375	3460.00	12.46	**16166850.00**	
Personal Supports Enhanced Supports	15 minutes	82	3460.00	15.79	**4479938.80**	
Respite Care Services Total:						**2832292.60**
Respite	15 minutes	186	1400.00	9.06	**2359224.00**	
Daily	Day	38	10.00	507.57	**192876.60**	
Hourly	Hour	0	350.00	38.40	**0.00**	
Camp	Item	88	1.00	3184.00	**280192.00**	
Support Broker Services Total:						**685392.00**
Support Broker Services	Item	218	12.00	262.00	**685392.00**	
Assistive Technology and Services Total:						**77963.00**
Assistive Technology and Services	Item	53	1.00	1471.00	**77963.00**	
Behavioral Support Services Total:						**400271.00**

GRAND TOTAL:	**25119309.70**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**47846.30**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Plan	Plan	61	1.00	1788.22	109081.42	
Assessment	Assessment	61	1.00	1788.22	109081.42	
Brief Supports Implementation	15 minutes	48	48.00	21.41	49328.64	
Consultation	15 minutes	68	48.00	40.68	132779.52	
Environmental Assessment Total:						11468.10
Environmental Assessment	Assessment	21	1.00	546.10	11468.10	
Environmental Modifications Total:						93513.00
Environmental Modifications	Item	21	1.00	4453.00	93513.00	
Family and Peer Mentoring Supports Total:						2726.40
Family and Peer Mentoring Supports (15 minutes)	15 minutes	8	20.00	17.04	2726.40	
Family and Peer Mentoring Supports (Hour)	Hour	0	5.00	77.65	0.00	
Family Caregiver Training and Empowerment Services Total:						1500.00
Family Caregiver Training and Empowerment Services	Item	3	1.00	500.00	1500.00	
Housing Support Services Total:						1524.80
Housing Support Services (15 minutes)	15 minutes	2	40.00	19.06	1524.80	
Housing Support Services (Hour)	Hour	0	10.00	80.50	0.00	
Individual and Family Directed Goods and Services Total:						54356.00
Staff Recruitment and Advertising	Items & Services	54	1.00	478.00	25812.00	
Good and Services	Items & Services	16	4.00	446.00	28544.00	
Nursing Support Services Total:						190938.00
Nursing Support Services	15 minutes	110	60.00	28.93	190938.00	

GRAND TOTAL:	25119309.70
Total Estimated Unduplicated Participants:	525
Factor D (Divide total by number of participants):	47846.30
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Education, Training and Advocacy Supports Total:						**1000.00**
Participant Education, Training and Advocacy Supports	Item	2	1.00	500.00	**1000.00**	
Transportation Total:						**44616.00**
Transportation	Item	22	12.00	169.00	**44616.00**	
Vehicle Modifications Total:						**74960.00**
Vehicle Modifications	Item	8	1.00	9370.00	**74960.00**	

GRAND TOTAL:	**25119309.70**
Total Estimated Unduplicated Participants:	**525**
Factor D (Divide total by number of participants):	**47846.30**
Average Length of Stay on the Waiver:	332