

## **Main**

- Please explain why the state is implementing changes July 1, 2019 instead of July 1, 2018, which is the beginning of the renewal/WY1.

The Community Pathways Waiver (CPW) renewal application enhances services and supports for individuals and families with the addition of new services, which some new services will be implemented in July 2018 and others in July 2019.

Career Exploration; Family and Peer Mentoring Supports; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote Support Services; and three new Nursing Services will be available July 1, 2018.

Employment Services, Supported Living, and Community Living – Enhanced Supports will be implemented in July 2019 to allow time for development of community setting compliant service providers; implementation of new rates and billing system; and the transition of the current Supported Employment and Employment Discovery and Customization services to the new Employment Services.

- Brief Waiver Description The description lacks information regarding Organizational Structure.

The following language will be added to this section:

Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the single state agency for Medicaid. MDH's Office of Health Services (OHS) is responsible for ensuring compliance with federal and state laws and regulations to the operation of the waiver. MDH's Developmental Disabilities Administration (DDA) is the operating state agency and funds community-based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four Regional Offices (RO): Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support the administrative, operations, and direct service delivery. Medicaid State Plan targeted case management (TCM) services are provided by licensed Coordination of Community Services (CCS) agencies. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations.

Services are provided by licensed community agencies and/or individuals and companies under the self-directed service delivery model. Fiscal Management Services (FMS) and Support Brokerage 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 people receive appropriate services oriented toward the goal of full integration into their community.

### **Attachment #1**

- Please describe within this section if the changes will be greater, less, or equal to the service limits, rates, etc. Please include how the individual will be informed of the opportunity to request a Fair Hearing.
- Please describe within this section how the health and welfare of individuals who receive these services will be assured through and after the transition.
- Please describe how and when individuals will transition with the changes, i.e. changes to person-centered service plan.

The following language will be added to this section:

Coordinators of Community Services (CCS) will share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process, beginning July 1, 2018. The Health Risk Screening Tool (HRST), conducted annually during the person-centered planning process, will be used to identify potential impact to a participant's health and welfare through and after existing services transition. The HRST assesses the individual'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. Upon making a decision affecting a participant's services, the DDA informs the individual and his/her family or 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.

### **SERVICE ENHANCEMENTS AND TRANSITIONS - MEANINGFUL DAY SERVICES**

Service changes will result in increased flexibility and opportunities for participants to receive more support hours of Meaningful Day services with the transition of service from a daily rate to an hourly rate. The rates will remain the same until new rates are finalized through the rate study.

### **SERVICE ENHANCEMENTS AND TRANSITIONS - RESIDENTIAL SERVICES**

Community Living – Group Home and Shared Living service scope has been updated. Community Living – Group Home rate will remain the same until new rates are finalized through the rate study. Shared Living rates will decrease as supplemental services are being transitioned to stand alone waiver services.

### **SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES**

Behavioral Support Services consultation and brief support implementation services will be limited to 8 hours per day. The rates will decrease.

Environmental Modification service limit changed from \$17,500 (combined with VM) lifetime to \$15,000 every 3 years.

Individual and Family Directed Goods and Service limit increased from \$2,000 to \$5,500 per year.

Live-in Caregiver Supports scope and rate increased with the addition of a food allowance.

Personal Support Services rate will remain the same until new rates are finalized through the rate study.

Respite is short-term day care that may not exceed \$7,248 annually. The type of respite chosen will impact the amount of daily, hourly, or camp with less daily and hourly options and more camp options. Participants seeking habilitation supports as an alternative to the basic day care break from the daily routine can seek additional Meaningful Day and Personal Support services.

Transportation limit increased from \$1,400 to \$7,500 per year.

Vehicle Modification limit changed from \$17,500 (combined with EM) lifetime to \$15,000 every 10 years.

### **Appendix A-6 Assessment Methods and Frequency**

- Please specify in this section the frequency in which assessments are conducted.

The following language edits in red will be made to this section:

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 ~~service delivery~~ **approval of invoices**.
6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks **annually** and provide 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.
8. LTSS Maryland - 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 - DDA audits service providers **annually** for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

## **Appendix B: Participant Access and Eligibility**

- Since the 1931 group has been separated into three distinct eligibility groups; other caretaker relatives specified at 435.110, pregnant women specified at 435.116, and children specified at 435.118, in Appendix B-4-b, the state should remove the checkmark from 1931 and check “Other.” Under “Other” the state should list the appropriate regulatory citation(s) for the group(s) of individuals being covered under this waiver amendment request, as reflected in your current approved Medicaid state plan.
- Children and pregnant and post-partum women at or below 250% of the FPL included in the state plan 1902(a)(10)(A)(ii)IX) and 1902(1). The state should be asked to revised the reference to this this group from 1902(a)(10)(A)(ii)IX) and 1902(1) to 435.116
- Children at least 1 year old and under 6 years of age with families incomes at or below 133% of the FPL 1902(a)(10)(A)(i)(VI) and 1902(1)(i)(C). The state should be

asked to revise the reference to this group from 1902(a)(10(A)(i)(VI) and 1902(1)(i)(C) to 435.118

- Children at least 6 year old and under 19 years of age with families incomes at or below 100% of the FPL 1902(a)(10(A)(i)(VII) and 1902(1)(i)(D). The state should be asked to revise the reference to 435.118.
- The state should be asked to remove the reference to Individuals ineligible for AFDC/TCA because of requirements that do not apply under title XIX of the Act 435.113. This is an obsolete group & currently no longer is covered under the Medicaid program.

Appendix B mirrors the recently approved Community Supports Waiver that was based on previous instructions from CMS. We suggest a call with appropriate staff specific to Appendix B if needed.

### **Appendix B-3-c Reserved Capacity**

- Please describe how the amount of reserved capacity was determined.

Reserved capacity is based on historic data, recent trends, and forecasted future needs. For example:

- There were 149 Emergencies in FY17 and 180 in FY18. We are reserving capacity for up to 200 per year.
- Families with Multiple Children on the Waiting List (WL) was based on data pull of number of families with more than one child on the DDA WL or Future Needs registry.
- Transitioning Youth (TY) was based on a data pull. TY are youth aged 20 – 21 years. DDA's Waiting List data includes age of person which can be sorted to identifying upcoming transitioning youth which can change daily. (See chart below)

Age	Total
18	394
19	601
20	710
21	598

The DDA also receives information from the Department of Human Services related to youth transitioning out of the foster care system with a developmental disability and participants aging out of the Autism Waiver that may meet the CPW eligibility. These trends were also considered. With the approval of the new Community Support Waiver (CSW), the projected total number of TY were distributed between the CSW or the CPW based on projected assessed needs for residential services.

- State Funded Conversions are based on current number of individuals meeting the waiver's level of care with ongoing State only funding for services. There are

approximately 1200 individuals who left the waiver during Fiscal Years 2000 – 2015 that are receiving ongoing State only funding for services. The State projects to support 300 individuals per year.

- Money Follow the Person trends demonstrated:

Fiscal Year	Transitions
2014	23
2015	26
2016	22
2017	20

The following categories are initial estimates based on anticipated need that will be reassessed and revised as more data becomes available:

- Military Families
- Previous Waiver Participant with New Service Need
- Family Supports Waiver Participant with Increased Needs
- Community Supports Waiver Participant with Increased Needs

### **Appendix C – Participant Services**

#### **Overall: Begin/End July 1, 2019 transition of services language**

- Please move or add the language describing the transition of old/new services to be the first sentence so it can be easily found and removed in an amendment after the transition has occurred. Also, please indicate if the service is beginning or ending. Also note details can be added to the service category to identify if the service is being terminated.

The State will add language to the services that are transitioning to indicate when they will begin or end.

#### **Career Exploration**

- Please review the taxonomy and core service definitions for prevocational and supported employment services under the HCBS Technical Guide beginning on page 150 and the CMS Informational Bulletin issued on 9/16/11 on employment and employment related services. Please review and revise the category and/or service definition. As written, the State has described supported employment services, but categorized as prevocational. The State has also included service settings that are prohibited under supported employment.

The category of service was selected to align with the CSW based on discussions with CMS related to the CSW submission.

#### **Community Living - Group Home**

- Trial experience – CMS is reviewing this issue and would like to discuss in detail.

Maryland is happy to further discuss trial experience. This option is currently available in the approved CSW known as "Community Exploration" under Residential Habilitation. Community Living - Group Home trial experience provides an opportunity for people transitioning from an institutional or non-residential site on a temporary, trial basis to experience group home living. The services are billed as an administrative cost.

- Please explain the statement: Group home services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.

Some individuals may spend time with their families during the weekends or go on a vacation away from the group home. In order for the provider to be paid for the unit of service, the participant must be in the home for at least six hours or spend the night.

#### **Day Habilitation services:**

- Please explain why the state included time limited paid/unpaid internships and apprenticeships under this service. These types of activities are vocational in nature and should be under prevocational and supported employment services.

Time limited paid/unpaid internships and apprenticeships language was recommended by a stakeholder workgroup as an introduction and exploration of vocational skills. This language is included in the CSW recently approved by CMS.

#### **Employment Services:**

- Please review the taxonomy and revise accordingly. The state has named the service "Case Management".

The taxonomy will be changed to "other" until the legacy Supported Employment service is phased out as the waiver portal does not support having more than one service with the same statutory service type.

- Please explain if the milestones have a time expectation or time limit, e.g. must be completed in 45 days of service plan meeting, etc.

Discovery includes three distinct milestones. It is expected that milestones would be completed within 90 days of service approval. The completion of each milestone is flexible and will be considered in conjunction with the participant's unique circumstances.

- Please include details explaining the milestone is not paid until the milestone has been fully completed as determined by state.

The State will add the following language to the service requirement B. "Each discovery milestone must be completed as per DDA regulations and policy with evidence of



completion of the required activities before being paid. Discovery Milestones must be completed in order, so Milestone #1 is to be completed, submitted and approved prior to Milestone #2 starting and Milestone #2 is to be completed, submitted and approved prior to Milestone #3 starting.”

- Please include details explaining who determines when the milestones have been reached.

The DDA or FMS will determine completion of the milestone.

- Please explain why follow-along supports are reimbursed as a monthly payment.

Follow-Along Supports are designed to be flexible and minimal in nature. They provide basic supports to someone successfully employed in competitive integrated employment. There are six (6) hours of support built into the service within a month. Individuals with a higher service level need would receive Ongoing Supports which are billed at an hourly rate.

### **Medical Day Care**

- Please revise the service definition to include the service is only permissible to adults (18 years and older); include the EPSDT assurance statement; *To the extent any listed services are covered under the Medicaid State Plan, including EPSDT, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.; and Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).*

This service definition correctly reflects that the medical day care service is permissible to individuals aged 16 years and older. The EPSDT assurance statement will be included in the service definition. The medical day care service definition for the Community Supports Waiver is incorrect and will be amended.

### **Personal Support, Respite, Supported Employment, Community Development services**

- Costs associated with requirements of training in order to be a qualified provider is not permissible as separate reimbursement, but may be included in the rate of reimbursement to the provider. Please remove this language and revise accordingly, “costs associated with staff training such as First Aid and CPR”.

This language is specific to the self-directed service delivery model and will be amended and moved to Service Requirement D. to reflect “Under the self-directed service delivery model, this service includes funding for staff **training**, benefits, and leave time subject to the following requirements:”



- Administrative costs should not be specified under the waiver, but included under the state's administrative cost allocation plan. Please remove this language and revise accordingly, "costs associated with training can occur no more than 180 days in advance of waiver enrollment".

This language is included in the FSW and CSW recently approved by CMS.

### **Assistive Technology**

- Please explain why remote health monitoring is also included under this service.

Remote health monitoring was included based on input from stakeholders. Examples include blood pressure bands, oximeters, etc. that can help promote and support the participant's independence.

- Administrative costs should not be specified under the waiver, but included under the state's administrative cost allocation plan. Please remove this language and revise accordingly, "costs associated with training can occur no more than 180 days in advance of waiver enrollment".

This language is included in the FSW and CSW recently approved by CMS.

- Please revise the assurance statement to include EPSDT: *To the extent any listed services are covered under the Medicaid State Plan, including EPSDT, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.*

The State used the standardized language recently approved in the Family Support and Community Supports Waiver which notes:

E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), Maryland State Department of Education, and Maryland Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

F. 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

### **Individual & Family Directed Goods/Services**

- Please explain what are the fees and activities that promote community integration.

Fees for activities that promote community integration include membership to organizations that enhance advocacy and self-direction.

### **Remote Monitoring Services**

- Please identify what type of assessment (is it a standard assessment?) will be used to determine the appropriateness of this service.

The participant's team will conduct a preliminary assessment by considering the person's goals, level of support needs, behavioral challenges, HRST, benefits, risk, and other residents in the home.

- Please identify who will make the determination and approve the service based on the assessment.

The DDA will make the determination and approval of the service.

- Please explain why this service is necessary for the individual to live in the home and community in order to avoid institutionalization.

Some people require staff for ongoing monitoring and oversight to increase independence, support health and safety, and minimize risk that can lead to institutionalization. Remote support services have been used in HCBS waivers for both older adults and people with developmental disabilities and Managed Long Term Care Services and Supports (MLSS) Medicaid programs to support independence and prevent institutionalization. Remote monitoring provides an alternative to direct staff for monitoring and two-way video chat with specially trained staff to help people live as independently as possible.

- When an individual's person-centered service plan specifies the need for overnight support, please specify how this service will ensure the individual's needs are being met and health/welfare are being addressed according to the individual's needs.

The scope of overnight support varies based on the person and level of support need. Some people require awake overnight staffing for direct intervention for health conditions (such as repositioning) or behavioral concerns (such as self-injurious behaviors). While other people may only need to have access to support or assistance.

The participant's team will conduct a preliminary assessment by considering the person's goals, level of support needs, behavioral challenges, HRST, benefits, risk, and other residence in the home. This assessment will determine whether remote support services are an appropriate option to meet the overnight needs of the person. Remote support services include the requirement for stand-by intervention staff for notifying emergency personnel, such as police, fire, and back-up support staff.

- Please describe in more detail where the monitors/sensors would be placed and where is the mainframe housed/located.

The positioning of monitors/sensors will be based on each participant's individualized assessed need, participant privacy, and consent of all residents. The mainframe will be located at the remote support service's agency.

- Please explain what is the estimated response time if a crisis were to occur.

Remote support services include the requirement for stand-by intervention staff for notifying emergency personnel, such as police, fire, and back-up support staff. Emergency personnel such as police and fire departments' response times are based on the distance to the home.

- Please explain if staff are prepared for prompt engagement and are they considered on duty or on call.

Service must be provided in real time, by awake staff at a monitoring base. Back-up staff must be available upon call.

- Please explain the back-up plan in the event the equipment fails e.g. power, alarms, etc.

In the event the equipment fails, back-up staff must be provided until the issue is resolved.

- Please explain how the individual and family will be informed and by what means in order to make an informed choice about this service.

The Coordinator of Community Service and residential provider will share information about this service option to include the assessment process, risk, benefits, and informed consent obtained.

- Please explain how individual's rights to privacy are met.

The participant's team will conduct a preliminary assessment by considering the person's goals, level of support needs, behavioral challenges, HRST, benefits, risk, and other residents in the home. The positioning of monitors/sensors will be based on each participant's individualized assessed need, participant privacy, and consent of all residents.

- Please explain if the device can/cannot be turned off by the individual and/or family.

The device cannot be turned off by the individual and/or family. In order to discontinue the use of the device, the person and team will need to reassess needs and identify the best strategy to meet the needs either by the remote supports or direct staffing.

- Please explain what control does the individual have over the equipment.

The person has the right to discontinue the remote support services by informing their Coordinator of Community Services.

- Please specify if remote support staff must undergo a background check.

Remote support staff must undergo a background check as per Appendix C-2-a.

### **Shared Living**

- Please explain in more detail the revisions made to shared living overseeing quality management/monitoring compliance, and compensation to host home for additional household cost.

Monitoring activities include a review of host home providers meeting minimum qualification requirements, such as first aid and CPR, and monthly stipend compensation to host home. This language will be removed and noted in regulations.

- Please note, recruiting for host home providers, facilitating recruitment/matching is not permissible. This type of activity should be included and specified under the state's administrative cost allocation plan. Please remove and revise the service definition accordingly.

This language will be removed and noted in regulations.

- Please explain the criteria that a participant does not have family or relative supports. What if the family or relatives are unable or unwilling to provide support? Are these individuals excluded?

No. The service supports people who do not have family or relative supports. This includes when existing family members and relatives are unable to provide supports.

### **Supported Living**

- Housing-related activities and services are only permissible under the distinct waiver service to provide assistance with community transition and integration. Assistance/facilitation with finding an apartment/home, roommates for shared living/residential habilitation service must be removed and may be included as administrative activities under the state's cost allocation plan.

This service is meant to be unlicensed congregate living and will be revised to mirror Community Living – Group Home with the exception of the home being a licensed site owned or operated by a provider. Participants will have a lease and control over the apartment/home, and the approved provider will provide the staffing supports. This

service model separates the staffing support services from housing, supporting people to remain in their home when choosing to change staff providers. This language will be removed and noted in regulations

- Please explain the activity of “overseeing quality management and monitoring compliance”.

Oversight and monitoring activities include:

1. Assessment progress on goals and outcome
2. Ensuring staff initially and continuing meet training requirements
3. Ensuring reporting of incidents as per DDA policy
4. Ensuring participant’s community setting rights are supported such as access to food, support in decorating their rooms as per their preferences, etc.

This language will be removed and noted in regulations.

### **Transition Services**

- Please revise the service definition to “another community residential setting that provides more independent living according to the individual’s needs and preferences. These services are not designed to pay for an individual to move from one group home to another group home.

The language will be revised to reflect:

Transition Services provide funding for allowable expenses related to the participant moving from (1) an institutional setting to a group home or private residence in the community, for which the participant or his or her legal representative will be responsible; or (2) a community residential provider to private residence in the community, for which the participant or his or her legal representative will be responsible.

- Please explain why transition services are billed as administrative services.

Transition services provided prior to moving out of an institution will be billed as an administrative service. This language has been approved in the FSW and CSW.

- Please note the goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan.

The transition goods and services must be linked to an assessed need.

### **Appendix C-5 Settings**

- Please describe how the state's regulations for the new settings and providers meet federal HCB settings requirements. All new settings and providers for these settings must be fully compliant at the time of submission. Please remove language indicating compliance by March 2022 and any setting that has not been determined to be fully compliant. This section pertains only to settings/providers that are fully compliant now and cannot be in the statewide transition plan. The language discussing settings and providers under the statewide transition plan should be removed and transferred to Attachment #2.

The State incorporated the HCB setting requirements into the Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, which notes: "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 §§D—F of this regulation and 42 CFR 441.301(c)(4)." and includes specific provider requirements. (Reference: <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.36.03-1.htm>)

Language related to compliance by March 2022 will be moved to Attachment #2 as per request.

- Please explain how enhanced support settings differ from other community living settings.

Community Living – Enhanced Support settings are new settings that support people with extreme behavioral challenges or court orders. These settings require Licensed Behavioral Analysis, Board Certified Behavioral Analysis, or Psychologist on staff or contracted and specialized training including trauma informed care, working with people with court orders, and crisis management models. Staffing levels include one to one and two to one supports.

- Please fully describe the settings (new) and how they meet federal HCB settings requirements, at the time of submission and in the future.

All new provider owned or operated settings include Community Living – Enhance Supports, Community Living – Group Homes, Day Habilitation, and Career Exploration must submit applications for new settings to DDA which are reviewed and assessed for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, onsite assessments are conducted.

- Please fully describe the means by which the state Medicaid agency ascertains that all (new) waiver settings meet federal HCB setting requirements, at the time of submission and ongoing.

All providers must submit applications for new settings to DDA which are reviewed and assessed for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, onsite assessments are conducted.

- Please explain the state's method of validating the provider self-assessment of compliance for enhanced support settings criteria before an individual is permitted to receive services in this setting.

Prior to final approval and Medicaid provider enrollment, onsite assessments are conducted.

#### **Appendix D-1-g Process for Making Service Plan Subject to Approval of SMA**

- Please describe the review process in which the SMA exercises oversight of service plans on a routine and periodic basis.

A retrospective representative sample of participant record will be reviewed on a quarterly basis to ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. The sample size will be based on a 95% confidence +/-5%. The review will be conducted by DDA staff.

#### **Appendix E-1-a Participant Direction of Services**

- Please explain how individuals will be assessed to meet the state established criteria, i.e. standardized assessment, etc.

The Coordinator of Community Services will meet with the person to describe the service models (self-directed and traditional) to support the delivery of DDA Waiver services. People interested in the self-directed service model will complete a questionnaire. The Self-Direction Interest Questionnaire will be completed prior to accessing this service model and annually thereafter as part of the Person-Centered Planning Process. It may also be re-administered at any time during the plan year if the Coordinator of Community Services or any other member of the team is concerned that the participant is at increased risk of health and safety issues as a result of self-directing or utilizing this service model.

If DDA has a reasonable belief, made in good faith, that the participant, or his or her designated representative is unable to make decisions so that there is (1) no lapse or decline in the quality of care; and (2) no increased risk to the health and safety of the participant, then DDA may deny or terminate the participant's utilization of the self-directed services model.



### **Appendix E-1-j Administrative Activity**

- Please explain how the support broker is paid under the FMS contract, but they are not employees of the FMS.

As per current practice, the FMS is responsible for paying for staff services and invoices for participant's self-directing services to include support brokers services. Similar to other waiver services like Personal Supports, Supported Employment, etc., they are not employees of the FMS but providers or vendors that the participant has selected to provide their services.

### **Appendix E-1-iv Administrative Claiming**

- Please specify the percentage of FMS costs relative to service costs.

Under current contracts, the percentage of FMS administrative cost compared to the participant's person-centered plan total budget varies based on the number of staff and vendors the participant uses during the year. The FMS administrative fees are associated with the number of staff and vendors utilized. Under the future contract, the FMS will be paid a flat monthly rate for all services that need to be performed for the individual.

### **Appendix E1-I Provision of FMS**

- Please update this section regarding the RFP for the FMS.

The Department of Budget and Management approved the RFP specifications. MDH is finalizing the details for the time and location for the pre-proposal conference to issue the RFP in May 2018 with services to begin January 2019.

### **Appendix E-1-k Independency Advocacy**

- Please explain the relationship of the advocates to DDA or other provider entities. Please identify by whom they are employed.

The DDA has contracts with the Advocacy Specialist to provide information and technical assistance for people self-directing services. They are not associated with providers of direct services.

### **Appendix E-2-b-ii & iv Participant exercise of budget flexibility**

- Please specify how the participant is informed of the budget amount before the service plan is finalized.

Participants are informed of the amount of their budget during the service plan development process. The self-directed budget is created from the person-centered planning process utilizing a cost detail and budgeting tool. Services to meet identified

needs are expressed in service units and frequency. A dollar value is assigned to the plan using the traditional service delivery system payment rates. This creates the total self-directed budget for which the participant can exercise employer and budget authority before finalizing and submitting to the FMS for execution.

- Please describe when prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change.

Prior review of changes are required by the DDA when new services are added, when existing services are deleted, and 5% increase or decrease of an approved service to ensure health and safety are not compromised by the changes.

### **Appendix G-2-a Use of restraints & restrictive interventions**

- Please describe the safeguards used for chemical and mechanical restraints. CMS has found only information for physical restraints.

As noted in G-2-b on page 279, 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 plan 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. 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.

- Under Practices to Ensure the Health and Safety of Participants, please be more specific or give a general overview of what is included under Title 7 of the Health General Article of the Maryland Annotated Code.

Title 7 Subtitle 10 - Rights of Individuals of the Health General Article of the Maryland Annotated Code includes basic rights such as access to a telephone; right to share room with a spouse; visitors; access to clothing and person effects; vote; receive, hold, or dispose of personal property; and receive services.

### **Appendix G-3 Medication Management**

- Please explain why the state did not complete this section since 24-hour/round-the-clock services are provided under this waiver.

This was an omission and will be completed.

## **Appendix I-1: Financial Integrity and Accountability**

- What is the frequency of the OIG Audits?

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

**CMS Response:** Update the waiver application to include this information.

- When the contractor selects providers for targeted audit after a remote audit, how does the contractor weigh various criteria for the selection? There are five criteria listed in the waiver application. Is there one that is weighted more heavily than another? If all remote audits demonstrate that all providers include all five criteria, which one would the contractor select?

Targeted audits are based on the presence of:

- a) Less services provided than billed;
- b) Less or more service provided than authorized in PCP (+/- >14%);
- c) Services provided did not match the definition of services billed;
- 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 weighted 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.

**CMS Response:** Update the waiver application to include the following language “No criterion is weighted 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.”

**We request no additional information.**

- Describe how the post-payment review process differs between agency-directed and participant-directed services. How does the contractor conduct a targeted review of a provider of self-directed services? Does the documentation under review differ from when a contractor reviews providers of agency-directed services?

The review is the same for traditional (agency-directed) and self-directed services.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

- How does the State ensure that the targeted audit and remote audit scope and method do not overlap? What methods do contractors employ specifically during the in-person, targeted review that is different from a remote review?

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 person's plan. The interview will include the person receiving services, his/her family or legal guardian, and Coordinator of Community Services, as appropriate.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

- Under what circumstances would the contractor expand the scope of the review?

The DDA will instruct the contractor to expand the scope of their review based on system issues present in their reporting findings.

**CMS Response:** Provide an example of system issues present in the report findings and include this in the waiver application. We request no additional information.

### **Appendix I-2: Rates, Billing and Claims**

- Please clarify the percentages that are being described. For example the rate for Environmental Assessments is based on BLS hourly wage job code 29-1122 and includes ERE 32.7%, PS 33% and training 13.4%. Does this mean that the base rate is BLS job code 29-1122 and then these extra percentages are added to the base rate to account for those components? (An extra 32.7% for ERE, 33% for PS and 13.4% for training?) The final rate being an extra 79.10% above the Base Rate? And then is there an additional 11.1% added on top of that for General Administration? I'm not following what you are attempting to describe.

Yes, the BLS hourly wage for job code 29-1122 (base wage rate) with each of the cost components percentages applied to the base wage rate to get a dollar amount are added together to get the total hourly rate. The assumption is 6 hours to complete the assessment to calculate the final rate for the service. The fee for service unit costs is included in Appendix J.

The rate setting methodology descriptions are based on CMS presentation: <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1b-transparent-documentation.pdf>

**CMS Response:** We request no additional information.

- Which year and/or job classification of BLS data did the State use to develop the BLS direct support professional base wage for each service? Provide the data or a link to this data.

The JVGA used the May 2015 State Occupational Employment and Wage Estimate. JVGA then accelerated the wage based on the Medicaid CPI. See page 32 of the Rate Setting Report. ([https://dda.health.maryland.gov/Pages/Rate\\_Study\\_Report.aspx](https://dda.health.maryland.gov/Pages/Rate_Study_Report.aspx))

**CMS Response:** Update the waiver application to include the “May 2015 State Occupational Employment and Wage Estimate” information regarding the BLS data used to formulate the direct support professional base wage. We request no additional information.

- Update the URL in the waiver application to reflect where the rate study is located ([https://dda.health.maryland.gov/Pages/Rate\\_Study\\_Report.aspx](https://dda.health.maryland.gov/Pages/Rate_Study_Report.aspx)).

The URL will be updated in the appendix.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

- Why does Assisted Technology not have a maximum allowable cost? What control measures are in place to ensure that spending is reasonable for each participant?

Assistive Technology includes various devices that are driven by market cost. Items that cost more than \$1,000 must be recommended by an independent evaluation of the participant’s needs. All requests are reviewed and approved by the DDA Regional Offices.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

- What is the methodology used to adjust the rate for each tier? How does the State account for adjustments made for provider effort, the intensity of services, support needs, and/or acuity? Does the State make any adjustments to the specific percentages for each rate component based on the specific tier of the rate, or is this constant for all tiers?

Adjustment will not be made to each rate component. Adjustment will be made for level of support need and dedicated staffing based on assessed need identified by the HRST, behavioral challenges, and other professional assessments.

**CMS Response:** How does the State adjust tiered rates based on level of support need or staffing? Does the State apply a standard percentage increase for each tiered service based on acuity level or staffing ratio? Are adjustments for each level of support /

staffing need determined for each service? If so, how did the State determine the adjustment for each?

**DDA Response:** Adjustment will be made for level of support need and dedicated staffing based on assessed needs identified by the HRST, behavioral challenges, and other professional assessments. See page 28 of the Rate Setting Report for an explanation of the tiered rate methodology at <https://dda.health.maryland.gov/Documents/JVGA%20DDA%20Rate%20Setting%20Report.pdf> Also, pages 32 and 37 include tiered rate development information.

- Is Personal Supports the only service subject to the 3.5 percent COLA adjustment from SFY 2016 - SFY 2019, or are other community-based services on the waiver also subject to this annual rate increase?

No, as was stated in the application in Appendix I, "The Maryland General Assembly passed legislation in 2014 mandating a 3.5% COLA for community based services providers for all community based services, including Personal Supports, beginning in State FY 2016 and continuing until State FY 2019."

**CMS Response:** We request no additional information.

#### **Appendix I -2: Rates, Billing and Claims, Flow of Billings**

- Please describe how self-directed providers are given the option to bill Medicaid directly. Or can only the FMS act on their behalf?

Only the FMS can submit claims on their behalf.

**CMS Response:** Update the waiver application to specify that only the FMS can submit claims on behalf of self-directed providers. We request no additional information.

#### **Appendix I -2: Rates, Billing and Claims, Billing Validation Process**

- Which entity is responsible for determining that the billed service is included in the participant's approved service plan under a self-directed service arrangement?

The FMS is responsible.

**CMS Response:** The current language in Appendix I-2-d of the waiver states that the operating agency is the entity responsible for reviewing the approved service plan under a self-directed service arrangement. Update the waiver application to remove this reference and include language stating that the FMS is responsible for determining that the billed service is included in the participant's approved service plan. We request no additional information.

- Describe the process for recouping payments for inappropriate billings.

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.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

- Describe the process for removing inappropriate billings from the FFP calculations.

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.

**CMS Response:** Update the waiver application to include this information. We request no additional information.

### **Appendix I -3: Financial Accountability, Payment**

- Please provide greater detail on the oversight of FMS providers. What is reviewed? How are the providers assessed? What is the criteria? Are all FMS providers reviewed or just a sample?

In addition to the utilization review by the independent contractor, the FMS RFP includes various requirements that will be overseen by the DDA and OHS contract monitors. 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 contractor will conduct satisfaction surveys and report the results of the surveys to the contract monitor on a quarterly basis. The contractor will also be required to provide an Annual Report.

**CMS Response:** Update Appendix I-3-b to include the above oversight methods. We request no additional information.

- What documentation does the State review when conducting the annual FMS audit? How does the State use this documentation to ensure the integrity of the financial transactions that they perform?

The utilization review contractor will conduct a remote audit of the 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 MDH.



The FMS contractor 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. The independent audit will assess at least 10% of the population of participants served by the contractor through a random selection process.

**CMS Response:** Update Appendix I-3-b to include the above oversight methods. We request no additional information.

- What is the scope of this review? Does the State review a representative sample of this documentation? 100 percent of self-directed providers?

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.

**CMS Response:** Update Appendix I-3-b to include the above oversight methods. We request no additional information.

### **Appendix I -3: Financial Accountability, Payment, additional Payment Arrangements**

- How is the provider arrangement with DDA voluntary?
- Is the provider free to cancel this arrangement? If not, how does this meet requirements for voluntary reassignment of payments outlined in the 1915(c) Technical Guide?

DDA service providers elect to become licensed or approved providers and acknowledge the voluntary reassignment of payments. DDA has one payment methodology for fee payment services (Residential, Day, Supported Employment, and Personal Supports). Providers agree to accept payments through this methodology.

**CMS Response:** Update Appendix I-3-g-i to include the above information. We request no additional information.

### **Appendix I -4: Financial Accountability, Non-Federal Matching Funds**

- Specify the source(s) of the local funds to offset the State's share of support of day habilitation and vocational services. State whether the underlying sources of these local funds meet applicable federal requirements.

Health-General §7-705 of the Maryland Annotated Code states that "For day habilitation and vocational services, the Administration shall also use local funds. The local funds shall be limited to the amount paid by each jurisdiction in fiscal year 1984."

These funds meet the applicable federal requirements. The DDA invoices the local jurisdictions for the appropriate amount and the jurisdictions pay the State by checks. These local funds are credited to the appropriate budget and are applied to the appropriate expenditures.

**CMS Response:** Update Appendix I-4-b to include the above information. We request no additional information.

#### **Appendix I -5: Financial Accountability, Exclusion of Medicaid Payment for Room and Board**

- Please describe in more detail the methodology used to assure room and board has been isolated and excluded from the payments for services in applicable residential settings.
- What are the specific methods the State uses to isolate and exclude room and board costs for Community Living - Group Home and Community Living - Enhanced Supports from rates paid to providers?

The DDA excluded the cost of room and board from service cost in determining payment rates for Community Living – Group Home and Community Living-Enhanced Supports. The Medicaid payment does not include either of the following items which the provider is expected to collect from the participant: (1) Room and board; or (2) Any assessed amount of contribution by the participant for the cost of care.

**CMS Response:** Update Appendix I-5 to include the above information. We request no additional information.

#### **Appendix I -6: Financial Accountability, Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

- I.6.1 - Please describe further how the State ensures that only the additional costs of rent and food of the live-in caregiver are considered.
- I.6.2 - Please describe how the state ensures that outlays made for the additional costs of rent and food for the live-in caregiver were incurred by the participant.
- I.6.3 - Please describe further the method of making payment for a live-in caregiver being routed through the provider but clearly provides for reimbursement of the participant.

Within a multiple-family dwelling unit, the actual difference in rental costs between a 1 and 2-bedroom (or 2 and 3-bedroom, etc.) unit is used to determine caregiver portion. Rental rates must fall within Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD). Within a single-family dwelling unit, the difference in rental costs between a 1 and 2- bedroom (or 2 and 3-bedroom, etc.) unit is based on the Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).

Live-in Caregiver Food is limited to the USDA Monthly Food Plan Cost at the 2 person moderate plan level. The participant will be reimbursed by the provider who will pass along the payments for eligible costs.

**CMS Response:** These are not contractor questions. We request no additional information.

## **Appendix J -2: Cost Neutrality Demonstration, Derivation of Estimates**

- How did the State develop the CAGR? What data did the State use to develop the CAGR? What years of data reflected this growth rate?

As stated in the application, the CAGR is the compound average growth rate developed from user and expenditure data from the Community Pathways CMS 372 reports for FY13 – 16.

**CMS Response:** Per the State's current language in Appendix J-2-c, the State applies multiple CAGR adjustments to different services across the waiver. The average annual Factor D growth rate for FY13-16 is 2.62 percent, but the State applies CAGR adjustments ranging from 2 percent to 15 percent. Does the State calculate a CAGR for user and expenditure data for each specific service? Why does the State elect to apply both a CAGR adjustment and COLA increase to their estimates?

**DDA Response:** The CAGR is calculated for each specific service and is applied to users only and not to expenditures. The COLA is applied to cost/unit only. The combination of growth in users and unit costs accounts for the growth in expenditures.

- How did the State develop their utilization estimates using the 372(s) Reports from FY13-FY16?

The CAGR for the service was applied to the user and expenditure date from the FY16 Community Pathways CMS 372 and trended forward unless otherwise stated.

**CMS Response:** How does the State use 372 reports from FY16, which report on only total costs and total users per service, to calculate their utilization estimates for WY1?

**DDA Response:** For some services, based on actual users and expenditures, actual units per user can be determined. As stated in the Waiver application, average units per user were based on historic utilization of services from the 372 Report as well as FY17 average units per user from data in PCIS2.

- For Factor D, the waiver describes a 2% COLA increase applied to all rate-based services in waiver years 2 - 5. What is the basis for this increase? Please describe the source of this assumption.

The average unit costs for rate-based services are estimated to increase by a 2% COLA based on historical authorized increases.

**CMS Response:** See requested information in question #1 regarding Factor D estimates above. We request no additional information.

- How did the State trend Factor D' forward from the SFY 2016 data to the WY1 estimate on the renewal?

Factor D' was calculated for Waiver Years 1-5 using FY16 actual MMIS Medicaid expenditures for Community Pathways Waiver participants enrolled in the Waiver at any point in FY2016 and trended forward with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** The State's FY2016 Factor D' value is \$9,864. When this value is trended forward to FY2019 (or 7/1/2018) by the 3.30 percent inflation rate, the resulting Factor D' for WY1 is \$10,873.12. Describe how the State arrived at their current WY1 Factor D' estimate of \$10,679.68.

**DDA Response:** The estimates were based on the FY15 372 Report and were never updated with FY16 numbers. We have updated in the Appendix.

- Provide the calculation the State used to arrive at the 3.3 percent inflation rate along with the specific data source.

Factor D' was calculated for Waiver Years 1-5 using FY16 actual MMIS Medicaid expenditures for Community Pathways Waiver participants enrolled in the Waiver at any point in FY2016 and trended forward with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** Update the waiver application to specify that the 3.3 percent inflation rate applied to Factor D' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. We request no additional information.

- How did the State trend Factor G forward from the SFY 2016 data to the WY1 estimate on the renewal?

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) FY16 report and trended forward for Waiver Years 1-5 with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** The State's FY2016 Factor G value is \$232,867. When this value is trended forward to FY2019 (or 7/1/2018) by the 3.30 percent inflation rate, the resulting Factor G for WY1 is \$256,689.98. Describe how the State arrived at their current WY1 Factor G estimate of \$257,437.09.

**DDA Response:** The estimates were based on the FY15 372 Report and were never updated with FY16 numbers. We have updated in the Appendix.

- Provide the calculation the State used to arrive at the 3.3 percent inflation rate along with the specific data source.

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) FY16 report and trended forward for Waiver Years 1-5 with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** Update the waiver application to specify that the 3.3 percent inflation rate applied to Factor G is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. We request no additional information.

- How did the State trend Factor G' forward from the SFY 2016 data to the WY1 estimate on the renewal?

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) FY16 report and trended forward for Waiver Years 1-5 with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** The State's FY2016 Factor G' value is \$5,030. When this value is trended forward to FY2019 (or 7/1/2018) by the 3.30 percent inflation rate, the resulting Factor G' for WY1 is \$5,544.58. Describe how the State arrived at their current WY1 Factor G' estimate of \$5,560.17.

**DDA Response:** The estimates were based on the FY15 372 Report and were never updated with FY16 numbers. We have updated in the Appendix.

- Provide the calculation the State used to arrive at the 3.3 percent inflation rate along with the specific data source.

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)

FY16 report and trended forward for Waiver Years 1-5 with the average inflation rate of 3.3% based on data from the Bureau of Labor Statistics CPI-U All urban consumers for medical care in Washington-Baltimore for years 2013-2016.

**CMS Response:** Update the waiver application to specify that the 3.3 percent inflation rate applied to Factor G' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. We request no additional information.

- For Career Exploration from WY1 to WY2, explain the increase in units/user and the decrease in cost/unit.

As stated in the application, “In Waiver Years 2-5, the estimated units per user for Community Development Services, Day Habilitation, and Career Exploration Services have been adjusted to reflect the unit change from a Day to an Hour and the removal of the limitation of receiving only one Day service per day.” Changing the unit of service changes the units/user and cost/unit.

**CMS Response:** Describe how the State calculated the unit/user and cost/unit changes for each of these services between WY1 and WY2. It is unclear how the State calculated the new average units per user and cost per unit in WY2.

For example, the State’s units/user for “Career Exploration – Large Group” in WY1 is 184.00 for a daily unit. The State’s WY2 estimate for units/user for an hourly unit is 368.00, or double that for a daily unit. How did the State determine that, on average, each user would utilize double the number of units annually?

Additionally, how did the State determine the new cost per unit for each component service from WY2-5 using the former daily cost per unit estimates? The State’s WY2-5 costs for just Career Exploration services decrease from a \$27 million service annually in WY1 to \$5.5 million annually in WY2. The State must provide slightly more information on how they determined the cost estimates for the services identified above.

**DDA Response:** As this service is similar to Supported Employment, in WY1 the estimates for unit/user and unit/cost mirror those for Supported Employment which were based on FY17 averages from PCIS2. In WY2, DDA assumes consumers will use an average of 2 hours of the service per day, so 184 days from WY1 converts to 368 hours in WY2. Also, in WY2 the new rates from the Rate Study are employed for the hourly unit of service.

- For Community Living-Group Home from WY1 to WY2, explain the increase in cost/unit.

As stated in the application, “The new rates for the remaining rate-based services will be adopted in FY20, or Waiver Year 2, as DDA transitions to a fee for service billing model, phases out the use of PCIS2 for claims submission and transitions to submitting claims using the LTSS financial management system. Therefore, in the transition year,



Waiver Year 1, the average costs per unit for the following services are based on average costs from PCIS: Community Development Services, Community Living Group Home Services...”

**CMS Response:** We request no additional information.

- For Day Habilitation from WY1 to WY2, explain the increase in units/user and the decrease in cost/unit.

As stated in the application, “In Waiver Years 2-5, the estimated units per user for Community Development Services, Day Habilitation, and Career Exploration Services have been adjusted to reflect the unit change from a Day to an Hour and the removal of the limitation of receiving only one Day service per day.” Changing the unit of service changes the units/user and cost/unit.

**CMS Response:** See additional information provided in above response regarding Career Exploration services.

**DDA Response:** In WY1, the estimates for unit/user and unit/cost for Day Habilitation are based on FY17 averages from PCIS2. In WY2, DDA assumes consumers will use an average of 2 hours of the service per day, so 206 days from WY1 converts to 412 hours in WY2. Also, in WY2 the new rates from the Rate Study are employed for the hourly unit of service.

## QIS

### Appendix A:

- AA - PM3: Number and percent of waiver policies approved by the OHS.  $N =$  Number of waiver policies approved by the OHS  $D =$  Total number of waiver policies issued.

Please review the data source, CMS is interested how record reviews and on sites will assist on compiling internal policy data.

The data source was selected in error and will be updated to reflect “Presentation of Policies or Procedures”.

**CMS Response:** We request no additional information.

### Appendix D:

- The State's performance measure (SP-2) “Number and percent of waiver participants who have their personal goals addressed in the service plan through waiver-funded services or other funding sources or natural supports” is sufficient to justify this portion of the sub-assurance, but the State must provide additional information regarding their sampling frequency. The State collects data for this



measure continuously, but measure SP1, which uses the same data source is collected quarterly.

Why does the State collect the data for this measure continuously, but collect the data quarterly for SP1?

This is an error and will be corrected to reflect quarterly.

**CMS Response:** Update the waiver application to indicate quarterly collection for SP1. We request no additional information.

- The State's performance measure(SP-3) "Number and percent of service plans reviewed and updated before the waiver participant's annual review date" is not sufficient to justify the entirety of the sub-assurance. The current measure does not address whether service plans are updated following a change in the participant's needs.

Update the current measure (or add a new measure) to address whether service plans are updated following a change in the participant's needs.

The State used the same measure that was recently approved by CMS in the Maryland's Family Supports and Community Supports Waivers. This measure will be assessed by conducting record reviews which includes assessing whether plans were updated following a change in the person's needs.

**CMS Response:** We request no additional information.

#### **Appendix G:**

- The State's performance measures are sufficient to justify the sub-assurance, but the State must update the denominators for these measures to address the universe of records reviews used as the data source. The current denominator is vague.

Update the denominator for this measure from "# reviewed" to "Number of participant records reviewed."

The State will update the language.

**CMS Response:** Update the waiver application to include the above denominator. We request no additional information.

- The State's performance measures are not sufficient to justify the sub-assurance. PM5 (Number and percent of critical incidents systemic interventions implemented.) refers to critical incidents systemic interventions, but the current structure of the measure would result in an unclear outcome. The State must provide additional information about this measure.

Under what circumstances would a critical incident systemic intervention exist but not be implemented? How do these interventions prevent further similar incidents?

The sub-assurance states: "The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further incidents to the extent possible." Maryland has three performance measures to demonstrate this assurance.

To demonstrate and assess our incident management system, we are measuring critical incident investigations initiated within the required timeframe and critical incident investigations completed within the required timeframe.

To demonstrate our efforts to "*prevent further incidents to the extent possible*", we also added a measure related to system interventions developed in an effort to prevent future critical incidents. These are the same measure that was recently approved by CMS in the Maryland's Family Supports and Community Supports Waivers.

**CMS Response: We request no additional information.**

- The State's performance measure "Number and percent of participants receiving Community Living – Group Home or Enhanced Supports whose identified health care needs are being addressed" is potentially sufficient to justify the sub-assurance, but the State must provide additional information prior to approval. The State's current measure only addresses whether healthcare standards, or in this case needs, for those receiving Community Living - Group Home or Enhanced Supports services. If there are additional standards that apply to other services within this waiver, those should be included here as well.

Are Community Living - Group Home and Enhanced Supports services the only two services on the waiver that have established health care standards / needs that must be met? If so, how does the State ensure standards of care are being met for other services on the waiver?

Yes, Community Living – Group Home and Enhanced Support services are the only two services that have health care standards.

The sub-assurance states: "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."

Community Living – Group Home and Enhanced Support services are provider owned and operated residential habilitation sites for which the provider is responsible for supporting the person is going to their health appointments. The waiver provides various Meaningful Day services (e.g. Employment Services, Community Development Services) and Supports services (e.g. Assistive Technology, Respite) to support competitive integrated employment, community integration, and independence.

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Meaningful Day and Support service providers are not responsible for supporting the person in going to health appointments.

**CMS Response:** We request no additional information.