Community Pathways Waiver

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

1. Request Information

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

B. Program Title:
Community Pathways Waiver

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

D. Amendment Number:MD.0023.R08.04

E. Proposed Effective Date: 10/06/25
Approved Effective Date:

F. Approved Effective Date of Waiver being Amended:

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

1. Streamline and enhance service delivery by merging the Family Supports Waiver, Community Supports Waiver, and Community Pathways Waiver into a single, comprehensive program—the Community Pathways Waiver. Participants will have access to the full array of support services, meaningful day services, and residential services, based on assessed needs. This will improve efficiency, ensure equitable access, provide a more person-centered approach to supports, and increase timely access to services.

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

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

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

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

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

Appendix B

1. Updated eligibility to include all ages. Expanding eligibility to all ages ensures that more individuals can access the services they need, and promotes person-centered services.

2. Updated total number of unduplicated participants incorporating the Family Supports and Community Supports participants.

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

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

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

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

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

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

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

5. Updated performance measure to include information gained from the Quality Improvement Organization Targeted Case Management Reviews. The Quality Improvement Organization conducts Targeted Case Management Reviews and analyzes information regarding individual and systemic deficiencies. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement. DDA considers

recommendations and has made updates to improve policies, waiver proposals, including improving performance measures based on this data.

Appendix C

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

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

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

Service Updates

1. Assistive Technology and Services –

a. Added Shift Enabling Technology Certification as an acceptable certification for a qualified Assistive Technology Specialist, expanding the pool of qualified providers.

b. Added monthly service fees as a covered service to support monthly fees associated with operating technology.

c. Removed personal emergency response systems as this service is covered under the Medicaid Community First Choice program.

2. Behavioral Support Services:

a. Expanding the pool of qualified providers:

(1) Removed requirements for high school or equivalent/higher for staff providing the Brief Support Implementation Services.

(2) Expanded qualified professionals that can complete the behavioral assessment and provide consultations to include a Licensed graduate-level professional counselor working under the license of the Licensed clinical professional counselor (LCPC) and Licensed masters-level social worker working under the license of the LCSW-C.

b. Improving quality of services:

(1) Clarified that recommendations for dedicated 1:1 and 2:1 support, enhanced supports, and overnight services must be in a Behavior Support Plan.

(2) Clarified Behavioral Consultation includes graphing and analysis of collected data to identify trends and patterns of target behaviors.

(3) Clarified requirements for progress notes.

3. Community Living - Enhanced Supports and Community Living - Group Home

a. Added language about dedicated supports can be provided for participants new to services and participants in services who have specific documented behavioral, or health and safety needs for up to 6 months while a Behavior Support Plan and

Nursing Care Plan gets authorized and developed. This allows participants to get necessary services during the development period and eliminates gaps in services.

b. Clarified that overnight staff must be awake and alert, ensuring health and welfare of participants.

c. Removed requirement for staff to have GED or high school diploma, expanding the pool of qualified providers.

4. Day Habilitation

a. Clarified that supports may be provided virtually in a participant's private residence and other DDA residential living arrangements, which allows greater access to services.

b. Added language that dedicated supports can be provided for participants new to services and participants in services who have specific documented behavioral, or health and safety needs for up to 6 months while a Behavior Support Plan and Nursing Care Plan gets authorized and developed. This allows participants to get necessary services during the development period and eliminates gaps in services.

5. Employment Support Services

a. Incorporates information from the DDA's Meaningful Day Services Policy including but not limited to:

(1) Clarified Discovery milestone requirements;

(2) Clarified Job Development includes strategic combination of both direct and indirect services;

(3) Clarified Ongoing Job Supports and Follow-Along Supports can be provided via remote technology (for example: Skype or Facetime) if preferred by the participant; and

(4) Clarified Follow-Along Supports include at least two direct face-to-face support contacts with the person in the course of the month, but may also include other types of interventions.

b. Incorporates information from the DDA's Competitive Integrated Employment Policy.

c. Clarified when seeking service authorization and/or re-authorization for Employment Services through Follow-Along Job Supports and/or Ongoing Job Supports, that a participant's job must have the qualities of competitive integrated employment.

d. Clarified training requirements for employment professionals in competencies.

e. Clarified service authorization for the Provider Managed Service Delivery Model.

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

7. Environmental Modifications

a. Added Smart home devices that require attachment to the home, such as voice activated door openers, blinds and shade openers as an option. This allows participants to access needed services and promotes independence.

b. Deleted age requirement for qualified provider, expanding access to services.

8. Family and Peer Mentoring Supports-

a. Language was clarified, as previously there had been confusion around the definition of mentors.

b. Removed the requirement for Bachelors Degree and added requirement for lived experience as a standard for family and peer mentors, recognizing life experiences (and not educational experience) as integral to peer supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

p. Establishes provider qualifications.

q. Limits Day-to-Day Administrative Supports may be provided up to 10 hours per month, and that providers can provide collectively for all participants they support up to 40 hours per week of Day-to-Day Administrative Supports.

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

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

13. Nursing Support Services –

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

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

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

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

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

15. Personal Supports

a. Clarified that overnight staff must be awake and alert.

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

c. Removed limitation of 82 hours for provider managed service delivery model.

d. Clarified the DDA may authorize an enhanced rate, 2:1 supports, and overnight services for participants new to services and participants in services who have a specific, documented behavioral or health and safety need for up to 6 months while a Behavior Support Plan and Nursing Care Plan gets authorized and developed.

16. Remote Support Services - provide the participant with the options to have control over the equipment, including the ability to turn off the remote monitoring device/equipment, if they choose to do so unless otherwise required as noted in a Behavioral Support Plan or Nursing Care Plan. This gives participants great autonomy and flexibility over their life.

17. Respite Services

a. Clarified State overnight or youth camps must be certified by the Maryland Department of Health.

b. Clarified respite may not be provided by the primary caregiver.

c. Removed day trips as part of respite.

18. Support Broker services –

a. Updated description and requirements based on the federal Center for Medicare and Medicaid technical guide. The updates are to simplify the information and to prevent duplication of activities with case managers and Day-to-Day Administrative Supports. Participants will receive the same level of support with no additional cost to the participant.

b. Clarified that service assists the participant with supported decision making related to employment related subjects.

c. Enhanced qualified providers to include required training and code of conduct.

d. Clarified non-billable administrative tasks.

e. Included that Support Brokers are required when the participant selects a relative, legal guardian, or legally responsible person as their designated representative, or when the participant employs any person or Provider to provide Day-to-Day Administrative Supports.

f. To ensure quality services, Support Brokers can provide collectively for all participants they support up to 40 hours per week of Support Broker Services.

g. Removed requirement for First Aid and CPR.

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

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

Appendix C-1

1. Clarified training for Coordinators of Community Services, in alignment with Code of Maryland Regulations 10.09.48. Training includes expectations related to integration and full access to the greater community, community setting rule, and person-centered planning.

2. Outlined the provision of virtual supports as an electronic method of service delivery, and defines how virtual supports are used to facilitate community integration, enhance the effectiveness of service delivery, improve accessibility, and ensure health and safety.

Appendix C-2

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

Appendix C-5

1. Defined relative as including a grandparent, step-grandparent, sibling, step-sibling, aunt, uncle, niece, and nephew. Clarified definition and scope of "Extraordinary Care" and the scope of legally responsible individuals, relatives, and legal guardians in providing extraordinary care.

2. Updated service delivery by a Legally Responsible Person, legal guardians, and relatives.

3. Clarified a request form and authorization is required before a Legally Responsible Person, legal guardians, and relatives exceed the upper limit of hours

authorized for a week. Currently, the request is submitted within the Person-Centered Plan.

4. Clarified that the Legally Responsible Person, legal guardians, and relatives will actively support hiring of employees or providers.

5. Clarified safeguards related to participant satisfaction, health and welfare through Coordinators of Community Services quarterly monitoring and follow-up activities.

6. Updated list of waiver services furnished by relatives/legal guardians to align with employer authority services options.

7. Clarified that services provided by a Legally Responsible Person, legal guardians, and relatives are subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

8. Defined emergency and unplanned departures and temporary exceptions to service delivery for Legally Responsible Person, legal guardians, and relatives. Requires participants to use a back-up plan and emergency plans prior to seeking exceptions. Submission of an overtime request, when necessary.

9. Clarified legal guardians, paid to provide guardianship services, may not provide paid Medicaid waiver program services to a participant.

10. Clarified what Medicaid waiver program services can be provided in the acute care hospital setting, and when direct support may be provided in those settings, to support the participant's personal, behavioral, and communication supports not otherwise provided in that setting.

Appendix D

1. Clarified an individual is ineligible for employment by a Coordination of Community Services provider organization if they are simultaneously providing services under a DDA-operated Medicaid waiver to a participant as the participant's employee or as the employee of a vendor or provider.

2. Clarified within each quarter of the Person-Centered Plan Annual Plan Date, at a minimum, the Coordinator of Community Service must monitor service delivery in

person at the place of service as specified in the approved Person-Centered Plan. The Coordinator of Community Service should visit the person in the setting of the service; and, for each quarterly visit, a different service setting.

3. Updated performance measure to include information gained from the National Core Indicators In-Person Surveys and Quality Improvement Organization Targeted Case Management Reviews.

4. Clarified the Quality Improvement Organization in collaboration with the Council on Quality and Leadership conducts Personal Outcome Measure interviews with participants and Basic Assurance interviews with providers to collect and analyze information regarding individual and systemic deficiencies.

5. Clarified the Quality Improvement Organization also conducts the National Core Indicators Survey and Targeted Case Management Reviews in an effort to measure and improve the performance of DDA's service system. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement.

6. Clarified State staff and Maryland Department of Health agents will conduct site visits, perform utilization reviews, and follow up on health and welfare concerns.

Appendix E

1. Clarified the participant and their legally authorized representative (as applicable) may direct their own services or designate a representative.

2. Added new mandatory DDA self-directed orientation/training for all new applicants and participants using the Provider Managed Service Delivery Model interested in the self-directed service delivery model. The training is to:

a. Support the applicant/participant to fully understand their rights, role and responsibilities under the self-directed service delivery model;

b. To ensure an informed decision prior to enrollment into the Self-Directed Service Delivery Model; and

c. The requirement is for the participant or their Designated Representative to complete the required training modules associated with the Self-Directed Training

Series. The participant is not required to complete or pass any test questions associated with the training.

3. Clarified Support Broker services are outlined in Appendix C.

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

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

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

c. A support broker that also provides direct support to the same person

5. Clarified that Support Broker Services are required if the participant employs a Day-to-Day Administrative support provider.

6. Clarified non-disclosure agreements with participants associated with the Medicaid waiver program services are prohibited for all providers of services and supports including employees, vendors, DDA Medicaid Providers, Coordinators of Community Services, and Financial Management and Counseling Services providers.

7. Clarified Financial Management and Counseling Services providers must provide timely responses and resolutions to participant requests.

8. Updated the number of participants using the Self-Directed Services Delivery Model with Family Supports and Community Supports participants.

9. Updated safeguards to include the Coordinator of Community Services quarterly and more frequently site visits including wellness checks. The DDA regional office staff including Quality Enhancement and Nurses will conduct site visits to follow-up on health and safety concerns and reported complaints and incidents. The Office of Health Care Quality will conduct site visits and investigations based on complaints and incidents reported.

10. Added that the DDA has the authority to terminate the participant's enrollment in the Self-Directed Service Delivery Model, without the ability to reapply for or enter the Self-Directed Service Delivery Model for any length of time under

established circumstances, including when the participant overutilizes authorized services. When participant overutilizes authorized services, before involuntarily terminating the participant from the self-directed services model, DDA may first:

a. Require the participant to meet with DDA and their team to review rights and responsibilities including the monitoring and usage of funding for authorized services; and/or

b. Require a corrective action plan.

Appendix F

1. Updated to include the new dedicated "Request a Fair Hearing. File an Appeal" website which includes plain language information, frequently asked questions, and option to submit fair hearing request online at: https://health.maryland.gov/mmcp/Pages/medicaid-appeal.aspx.

2. Updated case resolution conference to be specifically related to DDA eligibility determinations.

Appendix G

1. Clarified the Office of Health Care Quality (OHCQ) has the authority to investigate all incidents and providers (employees, vendors, and DDA providers).

2. Clarified provider's internally investigated incidents shall be reported within 1 working day of discovery. The provider agency is responsible for reviewing and investigating each of these incidents. Types of Internally investigated incidents are outlined within Policy on Reportable Incidents and Investigations and include but are not limited to the following: physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment.

3. Clarified the DDA website home page includes a link to information on how to report abuse or concerns. Information can be viewed at: https://health.maryland.gov/dda/Pages/Report%20Abuse.aspx

4. Updated performance measure to include information gained from the National Core Indicators In-Person Surveys and Quality Improvement Organization Health and Welfare Reviews.

5. Clarified the Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.

Appendix H

1. Clarified DDA Waiver Advisory Council with the purpose of creating meaningful engagement and a feedback loop with all interested stakeholders, and with a focus on people with lived experience. Participants will have the opportunity to advise in and provide recommendations to the DDA on system design, service delivery, and quality enhancement strategies for the DDA-operated Medicaid programs.

2. Clarified the Quality Improvement Organization evaluates and develops continuous quality enhancement processes related to performance. Its role is to support the DDA to identify gaps in system performance, guidance/policy and performance measure reporting in an effort to provide quality enhancement strategies that support improved system performance.

3. Added information related to the DDA seeking to achieve Network Accreditation from the Council on Quality and Leadership. Achieving Network Accreditation uses baseline performance and seeks system transformation by enhancing outcomes people experience.

Appendix I and J

1. Updated performance measures.

2. Clarified rate components associated with Community Living - Group Home, Community Living - Enhanced Supports, and Supported Living including use of the Bureau of Labor Statistics wage job code 21-1093.

3. Clarified payments for all Medicaid waiver program services are made through the approved Medicaid Management Information System.

4. Clarified Medical Day Care claims are submitted electronically for payment into the State's eMedicaid system which interfaces with the Medicaid Management Information System.

5. Updated assumptions, estimated users, average units, average cost, and total cost.

6. Added that in Waiver Year 3, the budget includes geographical differential rates of 10% above the standard rate for eligible services.

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)
X	Waiver Application	
□	Appendix A – Waiver Administration and Operation	
X	Appendix B – Participant Access and Eligibility	B-1, 2, 3, 4, and 6
X	Appendix C – Participant Services	C-1/C-3: Service Specification C-2:General Service Specifications C-5: Home and Community-Based Settings
X	Appendix D – Participant Centered Service Planning and Delivery	D-1 and 2
X	Appendix E – Participant Direction of Services	E-1 and 2
X	Appendix F – Participant Rights	F-1 and 2
X	Appendix G – Participant Safeguards	G-1 and 2

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	Component of the Approved Waiver	Subsection(s)
X	Appendix H - Quality Improvement Strategy	H-2 and 3
X	Appendix I – Financial Accountability	I-1,2, and 3
X	Appendix J – Cost-Neutrality Demonstration	J-1 and 2

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

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

MAIN

1. Request Information (1 of 3)

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services 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)

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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*

X *5 Years*

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 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 home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

X 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:

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:

X 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)**
- **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:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable
X This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

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

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

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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 is the single state agency ultimately responsible for administering Maryland's Medical Assistance Program. The Maryland Department of Health's Office of Long-Term Services and Supports is responsible for ensuring compliance with federal and state laws and regulations in the operation and administration of this and other Waiver programs. The Maryland Department of Health's Developmental Disabilities Administration (DDA) is the operating state agency operating this Waiver program and providing funds for community-based services and supports for eligible individuals with developmental disabilities in the State of Maryland. The DDA has a Headquarters and four Regional Offices across the State: Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support administrative tasks, operations, and direct service delivery. Medicaid State Plan targeted case management services are provided by certified Coordination of Community Services provider organizations. The Maryland Department of Health's Office of Health Care Quality performs licensing, surveys, and incident investigations of many of the DDA's licensed home- and community-based services providers. The Maryland Department of Health'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 authority. Each Coordinator of Community Services assists participants in developing a Person-Centered Plan, which identifies individual health and safety needs and supports that can meet those needs. The Coordinator of Community Services is also responsible for conducting monitoring and follow-up to assess the quality-of-service implementation.

Services are delivered under either the Self-Directed Services or Provider Managed ~~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 and local health departments) that meet applicable requirements in Appendix C prior to rendering services. For Provider Managed ~~Traditional~~ Services Delivery Model,

individual ~~individuals~~ providers and provider organizations are licensed or certified by the Maryland Department of Health; for the Self-Directed Services Delivery Model, the individual provider or provider organization must be certified or licensed by the Maryland Department of Health and confirmed by the Financial Management and Counseling Services provider as meeting applicable requirements. Providers offering career exploration, facility-based supports, day habilitation, licensed respite, community living-group home, and community living-enhanced supports waiver services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the participants own home such as employment services, personal supports, respite, and assistive technology and services must meet provider qualifications to be certified by the DDA. Financial Management and Counseling Services providers and Support Broker services are also provided for participants that use the Self-Directed Service Delivery Model ~~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 as a Quality Improvement Organization to:

1. Provide strategies that enhance the quality of life and help to ensure the health and wellbeing for individuals with intellectual and developmental disabilities.
2. Develop audit standards for the DDA's services including review cases and analyze patterns of services related to assessed need and quality review.
3. Conduct ongoing utilization reviews to safeguard against unnecessary utilization of care and services and to assure efficiency, economy, and quality of care.
4. Administer the DDA's National Core Indicators Surveys.

Termination of Participation

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

1. No longer meets the eligibility requirements;

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

3. Fails to use a Coordinator of Community Services;

4. Fails to use a Financial Management and Counseling Services provider if using the Self-Directed Delivery Model;

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

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

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

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

9. Dies.

Waiver Re-Enrollment

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

a. The individual meets eligibility requirements; and

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

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

a. During the same waiver year;

b. Within 90 days of termination; or

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

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

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

Public Input Summary

To be added post comment period

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.

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.**

X Combining waivers.

☐ Splitting one waiver into two waivers.

☐ Eliminating a service.

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

X 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).

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

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

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

Specify the transition plan for the waiver:

To streamline and enhance service delivery, the Maryland Department of Health is merging the Family Supports, Community Supports, and Community Pathways waiver programs into a single, comprehensive program—the Community Pathways Waiver. Participants will have access to the full array of support services, meaningful day services, and residential services, based on assessed needs. This will improve efficiency, ensure equitable access, provide a more person-centered approach to supports, and increase timely access to services. Participants will continue to receive their services without having to take any action related to eligibility or planning.

A. Participants and Stakeholder Communications and Supports

1. Participants will receive a letter from the Department informing them of the transition to the Community Pathways programs at least 30 days prior to the transition.

2. A frequently asked question document will be created, updated, and shared with stakeholders.

3. DDA will share information during community webinars and within the DDA Connections newsletter.

4. DDA will partner with advocacy organizations to also share information.

5. Information regarding the amendment and frequently asked questions will be noted on a dedicated Department webpage.

6. Coordinators of Community Services and DDA Regional Offices are also available to answer questions.

B. Technology Systems

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

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

1. MDThink Eligibility and Enrollment (E&E) system data patches will be used to:

a. End enrollment in the Family Supports and Community Supports waiver programs with an effective date of October 5 2025 and

b. Add enrollment into the Community Pathways waiver program with an effective date of October 6, 2025.

c. The updates will be completed over a dedicated release window in order to execute the data patches.

D. All pending applications and appeals will be converted to the Community Pathways program.

2. LTSS*Maryland* system:

a. Program enrollment information will be transmitted from the MDThink Eligibility and Enrollment (E&E) and Medicaid Management Information System (MMIS).

b. System updates and data patches will convert all applications, Person-Centered Plans, forms, and appeals associated with the Family Supports and Community Supports waiver programs participants to reflect the Community Pathways waiver program.

c. The updates will be completed over a dedicated release window in order to execute the data patches.

3. Medicaid Management Information System (MMIS)

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

4. Electronic Provider Revalidation and Enrollment Portal (ePREP):

The ePREP system is used for individual and community providers to apply and enroll to become a Medicaid provider including Medicaid waiver program providers.

a. The DDA will confirm all current Family Supports and Community Supports providers are also enrolled under the Community Pathways program.

(1) Technical assistance will be provided for any providers that are not current Community Pathways providers.

(2) Participants, whose providers choose not to become a Community Pathways provider, will be supported in choosing new providers.

b. System updates will be completed to add new provider types for individual behavior support specialists, nurses, occupational therapists and physical therapists for enrollment into Medicaid.

c. New categories of service will be added for individual providers who bill through the Financial Management and Counseling Services providers.

d. A streamlined process for enrollment of these new provider types will be utilized to support expedited provider enrollment.

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

C. Mandatory Self-Direction Training Requirement

In the fall, the DDA will begin sharing information regarding the mandatory DDA self-directed orientation/training required for all new applicants and participants using the Provider Managed Service Delivery Model interested in the self-directed service delivery model. The specific DDA Self-Directed Training series module will be required. Examples include: Module 1: Self-Direction Overview; Module 2: The Self-Directed Services Team; and Module 3: Person-Centered Planning.

a. The mandatory self-directed orientation/training must be completed before enrollment. There is no cost to participants to attend.

b. Individuals enrolled in the waiver with an effective date of October 6, 2025 through December 31, 2025, must complete the mandatory training by or before March 31, 2026 if not already completed.

D. Individual and Family Directed Goods and Services

Participants currently authorized funding above the $5,000 limit may access the authorized funding through the end of their Person-Centered Plan.

E. Assistive Technology - Personal Emergency Response System

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

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):