Community Pathways Waiver

Appendix C: Participant Services

Appendix C: Participant Services

C-1: Summary of Services Covered and Service Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	**Career Exploration**
Statutory Service	**Community Living - Group Home**
Statutory Service	**Day Habilitation**
Statutory Service	**Live-in Caregiver Supports**
Statutory Service	**Medical Day Care**
Statutory Service	**Personal Supports**
Statutory Service	**Respite Care Services**
Statutory Service	**Supported Employment *(phased out effective years 3, 4, and 5)***
Supports for Participant Direction	**Support Broker Services**
Other Service	**Assistive Technology and Services**
Other Service	**Behavioral Support Services**

Other Service	**Community Development Services**
Other Service	**Community Living - Enhanced Supports**
Other Service	**Employment Discovery and Customization** ***(phased out effective years 3, 4, and 5)***
Other Service	**Employment Services**
Other Service	**Environmental Assessment**
Other Service	**Environmental Modifications**
Other Service	**Family and Peer Mentoring Supports**
Other Service	**Family Caregiver Training and Empowerment Services**
Other Service	**Housing Support Services**
Other Service	**Individual and Family Directed Goods and Services**
Other Service	**Nursing Support Services**
Other Service	**Participant Education, Training, and Advocacy Supports**
Other Service	**Remote Support Services**
Other Service	**Shared Living**
Other Service	**Supported Living**
Other Service	**Transition Services**
Other Service	**Transportation**
Other Service	**Vehicle Modifications**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

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

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** Complete item C-1-c.

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

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

Training includes:

a. Home and community based service expectations related to integration and full access to the greater community;
b. Coordinating with other service delivery systems; and
c. Assessing service settings and Community Setting Questionnaire completion.
d. Person-Centered Planning development, including:

a. Person-Centered Thinking;
b. Person-Centered Planning cycle, timeline, roles and responsibilities;
c. Assessing needs and mitigating risk; and
d. Ability to work collaboratively with service providers, families, and community members.

d. **Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

1. Will any in-person visits be required?
☒ Yes
☐ No

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/
via telehealth.

☒The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:

Virtual supports is an electronic method of service delivery. Virtual support must ensure the participant's rights of privacy, dignity, respect, and freedom from coercion and restraint.

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

The Medicaid provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address virtual supports including privacy.

The Coordinator of Community Services are responsible for monitoring the implementation of the Person-Centered Plan on an ongoing basis. Within each quarter of the Person-Centered Plan Annual Plan Date, at a minimum, the Coordinator of Community Service must monitor service delivery in person at the place of service as specified in the approved Person-Centered Plan. The Coordinator of Community Service should visit the person in the setting of the service; and, for each quarterly visit, a different service setting. The Coordinator of Community Services also monitors that the

services and supports meet the participant's privacy, health and safety needs, and that the participants remain satisfied with their services and supports including virtual supports as identified in their approved Person-Centered Plan.

☒How the telehealth service delivery will facilitate community integration. Explain:

The purpose of virtual supports is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote the participant's ability to live independently, and meaningfully participate in their community. Virtual supports are geared towards intentional learning (e.g., career planning, taking skill building classes) and can also be used towards helping a person do something more independently like remote job coaching.

Virtual supports must support a participant to reach identified outcomes in their Person Centered Plan. Virtual supports may supplement in-person direct supports. Medicaid waiver program services may not be provided entirely via virtual supports.

The use of virtual supports must be agreed to by the participant as outlined in the participant's file and provider service implementation plan. Participants must have an informed choice between in-person and virtual supports. Virtual supports cannot be the only service delivery provision for the participant seeking the given service.

Virtual supports cannot be used for the Medicaid provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the Person-Centered Plan.

☒How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. Explain:

The provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address:

1. Identifying whether the participant's needs, including health and safety, can be addressed safely while they are using virtual supports;

2. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency; and

3. How a participant will get emergency interventions if the person experiences an emergency, including contacting 911 if necessary.

4. Providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22. Provider Program Service Plans must include details on how they will identify individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency by July 1, 2026, if not already included.

The Coordinator of Community Services monitors the services and supports to assess if they meet the participant's privacy, health and safety needs, hands on assistance/physical assistance (as applicable), and that the participants remain satisfied with their services and supports, including virtual supports, as identified in their approved Person-Centered Plan.

☒How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. Explain:

The provider must have written policies, train direct support staff on those policies, and advise people and their person-centered planning teams regarding those policies that address:

1. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency; and

2. Providers providing a Medicaid waiver program service through virtual supports must include it as a service delivery method in their provider Program Service Plan, required by Code of Maryland Regulations Title 10, Subtitle 22. Providers Program Service Plans must include details on how

they will identify individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present while services are being provided virtually, as indicated, in case the person needs hands on assistance/physical assistance, support with using technology, or experiences an emergency by July 1, 2026 if not already included.

The Medicaid provider is responsible for providing assistance with the use of technology. The Medicaid provider is also responsible for the cost associated with the provider obtaining, installing, implementing, or using virtual supports, such as equipment, internet, software applications, and other related expenses. These costs, in the delivery of new business models, are part of the provider's operating cost.

Coordinators of Community Services will assess and monitor the quality and effectiveness of virtual supports during the quarterly monitoring assessment and more frequently as noted in the Person-Centered Plan. If additional supports are needed they can be explored through person-centered planning. If there is a desire by the participant to change the way services are delivered, a revised Person-Centered Plan and provider service implementation plan will be required.

☒How the telehealth will ensure the health and safety of an individual. Explain:

Participants and their teams shall assess the quality and effectiveness of virtual supports to meet the participant's assessed needs and preferences in accordance with applicable Medicaid waiver program requirements, set forth in the Medicaid waiver application.

Virtual supports, including use of phones, cannot be used to assess a participant for a medical emergency. The DDA Provider must develop and maintain written policies to address processes for preventing and responding to a medical emergency during use of virtual supports, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies.

At a minimum, such policies must address:

1. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual supports;

2. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home) and ensuring they are present during provision of virtual supports in case the participant needs hands on assistance/physical assistance, support with using technology, or

experiences an emergency during provision of virtual supports; and

3. Processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.

4. The virtual supports must comply with all federal and State requirements, policies, guidance, and regulations.

Coordinators of Community Services will assess and monitor the quality and effectiveness of virtual supports during the quarterly monitoring assessment and more frequently as noted in the Person-Centered Plan. If there is a desire by the participant to change the way services are delivered, a revised Person-Centered Plan and provider service implementation plan will be required.

Coordinator of Community Services monitoring includes reviewing incident reports and identifying risks with the participant's health and safety. Health and safety concerns shall be reported to the DDA Regional Office Quality Enhancement staff. DDA Regional Office Quality Enhancement staff will review incidents and conduct investigations as per the Policy on Reportable Incidents and Investigations.

Appendix C: Participant Services

C-2: General Service Specifications

a. **Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

☐ **No. Criminal history and/or background investigations are not required.**

☒ **Yes. Criminal history and/or background investigations are required.** Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

This section describes the minimum background check and investigation requirements for providers under applicable law.

A participant self-directing and providers may opt to perform additional checks and investigations as it sees fit.

Criminal Background Checks

Current Regulations

The DDA's regulation requires providers to have criminal background checks prior to service delivery. DDA's regulations also require that each DDA-licensed and DDA-certified community-based providers complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System; or (2) a National criminal background check via a private agency, with whom the provider contracts. If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years."

The same requirements are required for participants self-directing services as indicated within each service qualification.

All Medicaid providers must complete this requirement for all of the provider's employees and contractors hired to provide direct care, whether in the provider managed or self-directed service delivery system. If this background check identifies a criminal history that "indicate[s] behavior potentially harmful" to participants receiving services, then the provider is prohibited from employing or contracting with the individual. See Code of Maryland Regulations (COMAR) 10.22.02.11, Maryland Annotated Code Health-General Article § 19-1901 et seq., and Code of Maryland Regulations Title 12, Subtitle 15. Code of Maryland Regulations 10.22.02.11B also provides the DDA discretion to prevent individuals from providing services.

Background screening is required for volunteers who:

(1) Are recruited as part of an agency's formal volunteer program; and
(2) Spend time alone with participants.

Criminal background checks are not required for people who interact with or assist participants as a friend or natural support, by providing assistance with shopping, transportation, recreation, home maintenance and beautification etc.

These requirements are also applied for all employees and staff of a participant self-directing services.

Child Protective Services Background Clearance

The State also maintains a Centralized Confidential Database that contains information about child abuse and neglect investigations conducted by the Maryland State Local Departments of Social Services. Individual providers and staff engaging in direct one-to-one interactions with children under the age of 18 must have a Child Protective Services Background Clearance.

State Oversight of Compliance with These Requirements

The Quality Improvement Organization, Office of Long Term Services and Supports, and Office of Health Care Quality review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations.

Annually the Quality Improvement Organization will review Financial Management and Counseling Services providers' records for required background checks of staff working for participants enrolled in the Self-Directed Services Delivery Model, described in Appendix E.

b. **Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

☒ No. The state does not conduct abuse registry screening.

☐ Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. S. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

c. **Required information (Appendix C-2-c) is now contained in C-5.**

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

☐ **No.** The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

☒ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.** *Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the*

amount of personal care or similar services provided by a legally responsible individual is "extraordinary care", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.

(a) THE TYPES OF LEGALLY RESPONSIBLE INDIVIDUALS WHO MAY BE PAID TO FURNISH SUCH SERVICES AND THE SERVICES THEY MAY PROVIDE

DEFINITIONS:

Extraordinary Care

Extraordinary care means care exceeding the range of activities that a legally responsible person would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to assure the health and welfare of the participant and avoid institutionalization.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal

obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

Spouse

For purposes of this Waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Relative

For purposes of this Waiver, a relative is defined as a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew.

Legal Guardian

For purposes of this Waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

The State makes payment to a legally responsible person, who is appropriately qualified, for providing extraordinary care for the following services:

1. Personal Supports

2. Respite

A legally responsible person may not be paid to provide these Waiver program services if it does not constitute extraordinary care as defined above.

A service provided by a legally responsible person is subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

(b) METHOD FOR DETERMINING THAT THE AMOUNT OF PERSONAL CARE OR SIMILAR SERVICES PROVIDED BY A LEGALLY RESPONSIBLE INDIVIDUAL IS "EXTRAORDINARY CARE", EXCEEDING THE ORDINARY CARE THAT WOULD BE PROVIDED TO A PERSON WITHOUT A DISABILITY OR CHRONIC ILLNESS OF THE SAME AGE, AND WHICH ARE NECESSARY TO ASSURE THE HEALTH AND WELFARE OF THE PARTICIPANT AND AVOID INSTITUTIONALIZATION

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

1. The participant is either a child or an adult with needs that meet extraordinary care beyond scope of what the legally responsible person would ordinarily perform for individuals of the same age who did not have a disability or chronic illness;

2. The legally responsible person is the choice of the participant, or the authorized representative of a minor, which is supported by the team;

3. There is a lack of qualified providers to meet the participants needs;

4. When a relative or spouse is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant; and

5. ~~The~~ A legal guardian, relative, or legally responsible person ~~provides~~ shall provide no more than 40-hours per week of ~~the~~ paid services per participant. This includes when the legal guardian, relative, or legally responsible person is an employee for one service and an individual provider ~~vendor~~ for another service. This includes any combination of hours worked by the legal guardian, relative, or legally responsible person as a self-directed participant employee, individual provider, or employee of a provider.

If a legal guardian, relative, or legally responsible person serves more than one participant, they can provide no more than 60-hours per week of paid services across all Medicaid waiver services and across all participants served.

6. If multiple legal guardians, relatives, or legally responsible persons are providing services, each participant may receive no more than 60-hours of paid support per week of authorized services from all legal guardians, relatives, or legally responsible persons in total.

A Substitute Judgement document is required for participants who have legally responsible individuals, legal guardians, or relatives providing services that have decision making authority over the selection of waiver service providers.

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legally responsible person, legal guardians and relatives are not allowed to provide direct care services.

(c) THE STATE POLICIES TO DETERMINE THAT THE PROVISION OF SERVICES BY A LEGALLY RESPONSIBLE INDIVIDUAL IS IN THE BEST INTEREST OF THE PARTICIPANT

To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan by the Coordinator of Community Services:

1. Choice of the legally responsible person to provide Waiver services truly reflects the participant's or the authorized representative of a minor's wishes and desires;

2. The provision of services by the legally responsible person is in the best interests of the participant and their family;

3. The provision of extraordinary care services by the legally responsible person is necessary based on the participant's needs identified in their Person-Centered Plan;

4. The services provided by the legally responsible person will increase the participant's independence and community integration;

5. There are documented steps in the Person-Centered Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis, should the legally responsible person acting in the capacity of employee no longer be available;

6. A written agreement that identifies people, beyond family members, who will support the participant in making their own decision, is completed; and

7. The legally responsible person must sign a service agreement to provide assurances to the DDA that they will actively support hiring of employees or providers to expand the circle of support and implement the Person-Centered Plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.

In addition, Support Broker Services are required under the Self-Directed Services Delivery Model, when a relative, legally responsible individual, representative payee, and guardian serve as paid staff in order to assure proper oversight and quality assurance as well as reduce conflicts of interest.

Effective April 1, 2026, participants seeking to use a legally responsible person to provide services must submit a request form. The request has to be approved before legally responsible person can begin providing services.

A Substitute Judgement document is required for participants who have legally responsible individuals, legal guardians, or relatives providing services that have decision making authority over the selection of waiver service providers.

(d) THE STATE PROCESSES TO ENSURE THAT LEGALLY RESPONSIBLE INDIVIDUALS WHO HAVE DECISION-MAKING AUTHORITY OVER THE SELECTION OF WAIVER SERVICE PROVIDERS USE SUBSTITUTED JUDGEMENT ON BEHALF OF THE INDIVIDUAL

Effective April 1, 2026, participants seeking to use a legally responsible person to provide services must submit a request form. The request has to be approved before legally responsible person can begin providing services.

A Substitute Judgement document is required for participants who have legally responsible individuals, legal guardians, or relatives providing services that have decision making authority over the selection of waiver service providers.

(e) ANY LIMITATIONS ON THE CIRCUMSTANCES UNDER WHICH PAYMENT WILL BE AUTHORIZED OR THE AMOUNT OF PERSONAL CARE OR SIMILAR SERVICES FOR WHICH PAYMENT MAY BE MADE

A legal guardian, relative, or legally responsible person can provide no more than 40-hours per week of ~~the~~ paid services per participant. This includes when the legal guardian, relative, or legally responsible person is an employee for one service and an individual provider ~~vendor~~ for another service. This includes any combination of hours worked by the legal guardian, relative, or legally responsible person as a self-directed participant employee, individual provider, or employee of a provider.

If a legal guardian, relative, or legally responsible person serves more than one participant, they can provide no more than 60-hours per week of paid services across all Medicaid waiver services and across all participants served.

If multiple legal guardians, relatives, or legally responsible persons are providing services, each participant may receive no more than 60-hours of paid support per week of authorized services from all legal guardians, relatives, and legally responsible persons in total.

(f) ADDITIONAL SAFEGUARDS THE STATE IMPLEMENTS WHEN LEGALLY RESPONSIBLE INDIVIDUALS PROVIDE PERSONAL CARE OR SIMILAR SERVICES

Coordinators of Community Services conduct quarterly monitoring and follow-up activities which includes accessing services delivery and participant's satisfaction and health and welfare.

(g) THE PROCEDURES THAT ARE USED TO IMPLEMENT REQUIRED STATE OVERSIGHT, SUCH AS ENSURING THAT PAYMENTS ARE MADE ONLY FOR SERVICES RENDERED

Annually, the DDA or its designees will conduct a randomly selected, statistically valid sample of services provided by legally responsible persons to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

☐ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

☒ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that

payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians

(a) THE TYPES OF RELATIVES/LEGAL GUARDIANS WHO MAY BE PAID TO FURNISH SUCH SERVICES AND THE SERVICES THEY MAY PROVIDE

DEFINITIONS

Relative

For purposes of this Waiver, a relative is defined as a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew.

Legal Guardian

For purposes of this Waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

Spouse

For purposes of this Waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Provider Managed Services Delivery Model may use a legal guardian or relative (who is not a spouse), who is appropriately qualified, to provide:

1. Community Development Services;
2. Employment Services;
3. Individual and Family Directed Goods and Services - Day-to-Day Administrative Support (relatives can provide this service if they are not also a legal guardian or legally responsible person);
4. Nursing Support Services;
5. Personal Supports;
6. Respite Care Services;
7. Shared Living (siblings only);
8. Support Broker;
9. Supported Living;
10. Transportation; and
11. Live-in Caregiver Supports (siblings only).

A service provided by a legal guardian or relative is subject to the same Person-Centered Plan and claims monitoring procedures that are applied to all Medicaid waiver services.

(b) CIRCUMSTANCES WHEN PAYMENT MAY BE MADE METHOD FOR DETERMINING THAT THE AMOUNT OF SERVICES PROVIDED BY A RELATIVE/LEGAL GUARDIAN

An unpaid legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's Person-Centered Plan:

1. The participant is either a child or an adult with needs that meet extraordinary care beyond scope of what the legal guardian or relative, would ordinarily perform for individuals of the same age who did not have a disability or chronic illness;
2. The legal guardian or relative is the choice of the participant, which is supported by the team;
3. There is a lack of qualified provider to meet the participant's needs;
4. When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant; and
5. The ~~unpaid legal guardian, or~~ relative ~~provides~~, unpaid legal guardian, or a legally responsible person shall provide no more than 40-hours per week of paid ~~the~~ services per participant. This includes any combination of hours worked by the legal guardian, relative, or legally responsible person as a self-directed participant employee, individual provider, or employee of a provider.

   If a relative, unpaid legal guardian, or legally responsible person serves more than one participant, they can provide no more than 60-hours per week of paid services across all Medicaid waiver services and across all participants served.

6. If multiple legal guardians, relatives, or legally responsible persons are providing services, each participant may receive no more than 60-hours of paid support per week of authorized services from all legal guardians, relatives, and legally responsible persons in total.

Effective April 1, 2026, participants seeking to use a a legal guardian or relative to provide services must submit a request form. The request has to be approved before the legal guardian or relative ~~legally responsible person~~ can begin providing services.

A Substitute Judgement document is required for participants who have legal guardians and relatives providing services that have decision making authority over the selection of waiver service providers.

Legal guardians, paid to provide guardianship services, may not provide paid Medicaid waiver program services to the participant they provide guardianship services.

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide services noted above.

(c) THE STATE POLICIES TO DETERMINE THAT THE PROVISION OF SERVICES BY A LEGAL GUARDIAN OR RELATIVE IS IN THE BEST INTEREST OF THE PARTICIPANT

To ensure the use of a legal guardian or relative (who is not a spouse) to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan by the Coordinator of Community Services:

1. Choice of the legal guardian or relative as the provider truly reflects the participant's wishes and desires;

2. The provision of services by the legal guardian or relative is in the best interests of the participant and their family;

3. The provision of extraordinary care services by the legal guardian or relative is necessary based on the participant's needs identified in their Person-Centered Plan;

4. The services provided by the legal guardian or relative will increase the participant's independence and community integration;

5. There are documented steps in the Person-Centered Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis; should the legal guardian or relative acting in the capacity of employee no longer be available;

6. A written agreement that identifies people, beyond family members, who will support the participant in making their own decision, is completed; and

7. The legal guardian or relative must sign a service agreement to provide assurances to DDA that they will actively support hiring of employees or providers to expand the circle of support and implement the Person-Centered Plan and provide the services in accordance with applicable federal and State laws and regulations governing the program.

In addition, Support Broker Services are required under the Self-Directed Services Delivery Model, when a relative, legally responsible individual, representative payee, and guardian serve as paid staff in order to assure proper oversight and quality assurance as well as reduce conflicts of interest.

Effective April 1, 2026, participants seeking to use a a legal guardian or relative to provide services must submit a request form. The request

has to be approved before the legal guardian or relative ~~legally responsible person~~ can begin providing services.

A Substitute Judgement document is required for participants who have legal guardians and relatives providing services that have decision making authority over the selection of waiver service providers.

(d) THE STATE PROCESSES TO ENSURE THAT LEGAL GUARDIAN OR RELATIVES WHO HAVE DECISION-MAKING AUTHORITY OVER THE SELECTION OF WAIVER SERVICE PROVIDERS USE SUBSTITUTED JUDGEMENT ON BEHALF OF THE INDIVIDUAL

Effective April 1, 2026, participants who have legal guardians or relatives providing services must have a signed Substituted Judgement document.

(e) ANY LIMITATIONS ON THE CIRCUMSTANCES UNDER WHICH PAYMENT WILL BE AUTHORIZED OR THE AMOUNT SERVICES FOR WHICH PAYMENT MAY BE MADE

The legal guardians, legally responsible person, or relatives ~~can~~ shall provide no more than 40-hours per week of paid services per participant. This includes when the legally responsible person, legal guardian, or relative is an employee for one service and an individual provider ~~vendor~~ for another service. This includes any combination of hours worked by the legal guardian, relative, or legally responsible person as a self-directed participant employee, individual provider, or employee of a provider.

If a legal guardian, legally responsible person, or relative serves more than one participant, they can provide no more than 60-hours per week of paid services across all Medicaid waiver services and across all participants served.

If multiple legal guardians, relatives, or legally responsible persons are providing services, each participant may receive no more than 60-hours of paid support per week of authorized services from all legal guardians, relatives, or legally responsible persons in total.

(f) ADDITIONAL SAFEGUARDS THE STATE IMPLEMENTS WHEN LEGAL GUARDIAN OR RELATIVES PROVIDE SERVICES

Coordinators of Community Services conduct quarterly monitoring and follow-up activities which includes accessing services delivery and participant's satisfaction and health and welfare.

(g) THE PROCEDURES THAT ARE USED TO IMPLEMENT REQUIRED STATE OVERSIGHT, SUCH AS ENSURING THAT PAYMENTS ARE MADE ONLY FOR SERVICES RENDERED

Annually, the DDA or its designees will conduct a randomly selected, statistically valid sample of services provided by legal guardians and relatives to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.

☐ **Other policy.** Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The DDA is working with provider associations and currently enrolled Medicaid service providers to share information about new opportunities to deliver services to waiver participants.

The DDA website includes:

1. The MDH - Application and Approval Processes for DDA Qualified Supports/Services Providers. This document:

a) Describes specific requirements for completion and submission of initial application for prospective providers and renewal applications for current providers seeking DDA approval to render supports, services and/or goods under the DDA-operated Medicaid waiver program,
b) Provides definition and eligibility requirements for qualified service professionals regarding each support or service rendered, and
c) Delineates actions taken by the DDA following receipt of an applicant's information and provides timelines for review and approval or disapproval of an application.

Upon receipt of a new application, the applicable DDA regional office will review the application —within 30 days and an approval or denial letter is sent.

2. Eligibility Requirements for Qualified Supports and Services Providers - A document that describes each support and/or service and the specific eligibility criteria required to render the support/service.

3. Instructions for Completing the Provider Application - Interested applicants may download or request a hard copy from the DDA Regional Office for the following:

a) DDA Application to Render Supports and Services in the DDA-operated Medicaid waiver program; and

b) Provider Agreement to Conditions of Participation - A document that lists regulatory protection and health requirements, and other policy requirements that prospective providers must agree and comply with to be approved by the DDA as a qualified service provider in the supports waiver; and

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

Interested community agencies and other providers can submit the MDH application and required attachments at any time. For services that require a DDA license, applicants that meet requirements are then referred to the Office of Health Care Quality to obtain the license.

Support brokers may be sanctioned for violating DDA's waiver requirements, statutes, regulations, policies, guidance, instructions, or the support broker's agreements with the Maryland Department of Health or DDA. Sanctions include submitting a corrective action plan, withholding payment, recovery of an overpayment, suspension from providing services to participants, or de-certification from providing services to participants with a bar on re-applying to provide support broker services for any length of time. By way of example and not limitation, sanctions would be available for overutilization of authorized services, billing for two or more participants at the same time, and billing for support broker services provided by staff that DDA has not certified as support brokers. Support brokers will have an opportunity to appeal in accordance with COMAR 10.01.03.

g. **State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide waiver HCBS in acute care

hospitals. Select one:

☐ No, the state does not choose the option to provide HCBS in acute care hospitals.

☒ Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:

☒ The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

☒ The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

☒ The HCBS must be identified in the individual's person-centered service plan; and

☒ The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify:

a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;

b) How the 1915(c) HCBS will assist the individual in returning to the community; and

c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

a) The following Medicaid waiver program services can be provided in the acute care hospital setting:

1. Community Development Services;

2. Day Habilitation Services;

3. Personal Support Services;

4. Community Living - Group Home Services;

5. Community Living - Enhanced Support Services;

6. Supported Living Services.

b) Direct Support Professional staffing services may be provided in an acute care hospital for the purposes of supporting the participant's personal, behavioral, and communication supports not otherwise provided in that setting. These supports will assist the participant in communicating their needs and utilizing behavioral strategies to support healing, use of medical strategies to address the acute care health issues, and discharge to their community.

c) There are no differences in the rate billed for these services.

Appendix C: Participant Services
Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*Sub-Assurances:**

i. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

<table>
<tr><td>Performance Measure:</td><td colspan="2">Qualified Providers - Performance Measure 1 - Number and percentage of newly enrolled licensed/certified providers who meet standards prior to service provision. Numerator = number of newly enrolled licensed/certified providers who meet standards prior to service provision. Denominator = total number of newly enrolled licensed/certified Providers reviewed.</td></tr>
<tr><td colspan="3">Data Source (Select one) (Several options are listed in the on-line application): Other</td></tr>
<tr><td colspan="3">If ‘Other’ is selected, specify: Quality Improvement Organization Qualified Provider Review</td></tr>
<tr><td>Responsible Party for data collection/generation (check each that applies)</td><td>Frequency of data collection/generation: (check each that applies)</td><td>Sampling Approach (check each that applies)</td></tr>
</table>

☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
☒ Other Specify: Quality Improvement Organization	☒ Annually	Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Performance Measure:	***Qualified Providers - Performance Measure 2 -*** *Number and percentage of licensed/certified providers who continue to meet standards. Numerator = number of licensed/certified providers who continue to meet standards. Denominator= Total number of currently enrolled licensed/certified providers reviewed.*	
Data Source (Select one) (Several options are listed in the on-line application)*: Other*		
If 'Other' is selected, specify: *Quality Improvement Organization Qualified Provider Review*		
Responsible Party for data collection/generation (check each that applies)	**Frequency of data collection/generation:** (check each that applies)	**Sampling Approach** (check each that applies)
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative

		Sample; Confidence Interval = 95% +/-5%
☒ Other Specify: Quality Improvement Organization	☒ Annually	Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

b. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**Qualified Providers - Performance Measure 3 - Number and p**ercentage of paid claims provided by qualified non-licensed/certified providers (including Organized Health Care Delivery System individual providers ~~vendors~~, self-directed staff, and self-directed non-licensed providers). Numerator = number of paid claims provided by qualified non-licensed/certified providers Denominator = total number of paid claims.
Data Source (Select one) (Several options are listed in the on-line application)*: Other*	
If 'Other' is selected, specify: *Quality Improvement Organization*	

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

c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**Qualified Providers - Performance**

	Measure 4 -Number and percentage of paid, self-directed service claims, provided by qualified providers (includes employees, individual providers ~~vendors~~, providers and OHCDS). Numerator = number of paid, self-directed service claims, provided by qualified providers. Denominator = total number of self-directed services paid claims reviewed.

Data Source (Select one) (Several options are listed in the on-line application)*: Other*

If 'Other' is selected, specify: *Quality Improvement Organization Utilization Review*

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

Performance Measure:	**Qualified Providers - Performance Measure** 5 - Number and p*ercentage of paid claims whose services were provided by trained staff.*

	Numerator = number of paid claims whose services were provided by trained staff. Denominator = total number of paid claims.	
***Data Source (Select one) (Several options are listed in the on-line application)**: Other*		
***If 'Other' is selected, specify:** Quality Improvement Organization Utilization Review*		
Responsible Party for data collection/ generation (check each that applies)	**Frequency of data collection/generation:** (check each that applies)	**Sampling Approach** (check each that applies)
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
☒ Other Specify: Quality Improvement Organization	☒ Annually	Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual

problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Participants self-directing their services may request assistance from the Advocacy Specialist or the DDA Self-Direction lead staff. The DDA staff will document encounters.

The DDA's Provider Services staff provides technical assistance and support on an on-going basis to licensed and certified providers and will address specific remediation issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. These remediation efforts will be documented in the provider's file.
The Quality Improvement Organization in collaboration with the Council on Quality and Leadership conducts Personal Outcome Measure interviews with participants and Basic Assurance interviews with providers to collect and analyze information regarding individual and systemic deficiencies. The Quality Improvement Organization also conducts the National Core Indicators Survey in an effort to measure and improve the performance of DDA's service system. The Quality Improvement Organization shares findings with DDA and provides recommendations on remediation and overall quality enhancement. DDA considers recommendations and has made updates to improve policies, waiver proposals, including improving performance measures based on this data.

ii. Remediation Data Aggregation

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

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

☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☒ Other Specify: Quality Improvement Organization	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☐ **No**

☒ **Yes**

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

The following quality improvement activities are designed to improve compliance with the Qualified Provider performance measures. ~~the below~~

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

a. The DDA's Provider Services staff will notify providers via email and include a provider self-assessment tool at least 120 days prior to the DDA license approval expiration date to submit the renewal application. Providers must complete the tool by 90 days prior to DDA license approval expiration date. Technical assistance will be available throughout the process.

b. The DDA's Provider Services staff will meet with providers 75-90 days prior to the renewal date to review a provider self-assessment tool, if needed, to assess current status, updates, challenges, and concerns

related to their renewal application, Program Service Plan(s), Quality Assurance Plan, Community Settings, incident reporting, and provider performance. Technical assistance will be provided, and remediation strategies and due dates developed as applicable.

c. The DDA's Regional Offices will meet with the provider's Executive Director/Chief Executive Officer and Board President for all providers that have not submitted their application for renewals 60 days prior to the expiration date. The meeting will include the provider's proposed workplan with milestones and due dates. Meetings may also be scheduled to discuss other provider-specific concerns.

d. The DDA's Director of Provider Services will track, monitor, and report findings and trends to DDA management; and

e. The DDA will share the renewal application with the Office of Health Care Quality, upon receipt from the provider for a simultaneous dual review of all documents.

2. Measure: Licensed providers staff meet training requirements.

a. To ensure provider staff have the required training, the DDA Providers Services team or it's designee will collect training attestations for each provider quarterly.

b. The Quality Improvement Organization will conduct a statistically random sample to confirm compliance.

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The state imposes additional limits on the amount of

waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. (Specify and describe the types of settings in which waiver services are received.)

The Community Pathways Waiver services include various employment, meaningful day, support, and residential services. Waiver services are provided in the individual's own home or the community which is available for the public to use and visit and therefore presumed to meet the HCB Settings requirement. All providers and settings must comply with all the settings criteria in 42 CFR § 441.301. Effective January 1, 2018, to be enrolled as a provider of services authorized under §§1915(c) or 1915(i) of the Social Security Act, the provider shall comply with the provisions of this regulation and 42 CFR 441.301 and includes specific provider requirements.

The following services are provided at licensed sites which must comply with the home and community-based settings requirement prior to enrollment as a waiver service provider:

1. Community Living-Group Home at provider operated residential sites.

2. Community Living-Enhanced Supports are services provided at provider operated residential sites.

3. Day Habilitation services are provided at provider operated sites and in the community.

4. Career Exploration –services are provided at provider operated sites and in the community.

5. Medical Day Care services are provided at provider operated sites and in the community.

6. Respite Care Services can be provided in the participant's home, a community setting, a Youth Camp certified by Maryland Department of Health, or a site licensed by the Developmental Disabilities Administration. There are no residential services provided.

2. Description of the means by which the state Medicaid agency ascertains that all settings in which HCBS are received meet federal HCB settings requirements, at the time of this submission and in the future as part of ongoing monitoring. (Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)

All new providers must comply with the home and community-based settings requirement prior to enrollment as a new waiver service provider and ongoing. As part of the application process to become a Medicaid provider under the Waiver, the DDA will review and assess for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, the DDA will conduct site visits for site-based services to confirm compliance with the home and community-based settings requirements.

Each site is assessed for home and community-based settings compliance, utilizing the Community Settings Checklist prior to approval. Following initial approval, sites are assessed for compliance every 3-5 years and more frequently as needed. For sites that were approved prior to the compliance date of March 17, 2023, they are assessed for compliance every 3-5 years from the compliance date and more frequently as needed.

As per Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, any modification of the rights or conditions under §§D and E of this regulation shall be supported by a specific assessed need and justified in the person-centered services plan in accordance with 42 Code of Federal Regulations 441.301(c)(2)(xiii).

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

DDA reviews Community Setting Questionnaires flagged as potentially not meeting standards. DDA follows up with the Coordinator of Community Services and provider agency and remediate as applicable. DDA actions may include conducting an on site assessment and issuing corrective action as needed.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

☒ The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

☒The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

☒ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

☒ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

☒ Facilitates individual choice regarding services and supports, and who provides them.

☒ Home and community-based settings do not include a nursing facility, an

institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

☐ No, the waiver does not include provider-owned or controlled settings.

☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):

☒ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

☒ Each individual has privacy in their sleeping or living unit:
- ☒ Units have entrance doors lockable by the individual.
- ☒ Only appropriate staff have keys to unit entrance doors.
- ☒ Individuals sharing units have a choice of roommates in that setting.
- ☒ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

☒ Individuals have the freedom and support to control their own schedules and activities.
☒ Individuals have access to food at any time.
☒ Individuals are able to have visitors of their choosing at any time.

☒ The setting is physically accessible to the individual.
☒Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c) (4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (see Appendix D-1-d-ii of this waiver application).