Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The DDA approves ~~certifies~~ and contracts with provider organizations, which provide appropriately qualified staff, known as Coordinators of Community Service, to provide case management services to participants through the Medicaid State Plan Targeted Case Management for People with Developmental Disabilities authority.

Minimum Qualifications

Each Coordinators of Community Service assigned to an applicant/participant must meet the following minimum qualifications specified in Medicaid's Targeted Case Management regulations for people with developmental disabilities and DDA's regulations set forth in the Code of Maryland Regulations 10.09.48.05 and 10.22.09.06, respectively, as amended.

~~As provided in Medicaid's Targeted Case Management regulations, Coordinators of Community Service if an individual has been~~

~~employed by a DDA-certified Coordination of Community Service agency as a Coordinators of Community Service for at least 1 year as of January 1, 2014.~~

Under Medicaid's Targeted Case Management regulations, Coordinators of Community Service:

1. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;

2. Ensure that each individual receives a person-centered plan that is designed to meet the individual's needs and in the most cost effective manner; and

3. Annually advise participants of their right to choose among qualified providers of services to include Coordination of Community Services.

Ineligibility for Employment

~~As provided in Medicaid's TCM regulations, an~~ An individual is ineligible for employment by a Coordination of Community Services provider organization or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed or certified provider organization and entity;

2. Is 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.

3. Is on the Maryland Medicaid exclusion list;

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

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

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

7. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland, unlawfully interfering with the rights of an individual with a disability; or

8. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to participants receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and Code of Maryland Regulations 12.15.02

Necessary Skills for a Coordinator of Community Services

In accordance with Medicaid's Targeted Case Management Code of Maryland Regulations 10.09.48.05, Coordinators of Community Services must demonstrate competency-based skills and working knowledge in the following areas:

1. Negotiation and conflict management;

2. Crisis management;

3. Community resources including generic programs, local programs, State programs, and federal programs and resources;

4. Determining the most integrated setting appropriate to meet the participant's needs;

5. Coordinating and facilitating planning meetings;

6. Assessing, planning, and coordinating services;

7. Monitoring the provision of services to participants;

8. Allied service delivery systems, including Medicaid, mental health, substance abuse, social services, juvenile justice, vocational rehabilitation, and corrections; and

9. Regulations governing services for participants with developmental disabilities.

~~Each Coordinators of Community Services must possess the skills necessary to:~~

~~1. Coordinate and facilitate planning meetings;~~

~~2. Create Person-Centered Plans;~~

~~3. Negotiate and resolve conflicts;~~

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

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

Required Staff Training

All ~~DDA-certified~~ Coordination of Community Service providers shall ensure through appropriate documentation ~~and document~~ that each Coordinator of Community Services, Coordinator of Community Services Supervisor, and Quality Assurance ~~Staff~~ staff member receives any training required by the DDA including Person-Centered Planning Development. ~~person-directed and person-centered supports focusing on goals and outcomes.~~

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

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b. **Service Plan Development Safeguards.** *Select one:*

☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only***

willing and qualified entity in a geographic area who can develop the service plan:

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. By checking each box, the state attests to having a process in place to ensure:

☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

☐ Direct oversight of the process or periodic evaluation by a state agency;

☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The Coordinator of Community Services provides the participant and their legally authorized representative, (as applicable) ~~their legal guardian or authorized representative(s) (if applicable), and their family members (if appropriately authorized by the participant),~~ with written and oral information about DDA services and the process of developing a Person-Centered Plan. The Coordinator of Community Services assists the participant and their team by facilitating the team meeting and creating a Person-Centered Plan. This includes explaining assessments, timelines, and any other necessary steps. The information is shared in ways that are easy to understand, using written and spoken communication. If needed, the Coordinator of Community Services will use methods like sign language, assistive technology, or interpreter services to ensure the involvement of the participant.

A mandatory DDA self-directed orientation/training is required 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; and
b. To ensure an informed decision prior to enrollment into the Self-Directed Service Delivery Model.

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

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. If not completed by March 31, 2026, the participant will be transitioned to the Provider-Managed Service Delivery Model.

(b) The Coordinator of Community Services provides each participant, and their legally authorized representative, (as applicable) ~~their legal guardian or authorized representative(s) (if applicable), and their family members (if appropriately authorized by the participant)~~ with information about the participant's rights to determine their person-centered planning team. The participant and their legally authorized representative, (as applicable) ~~or their legal guardian or authorized representative(s) (if applicable),acting on~~

~~the participant's behalf,~~ are encouraged to ~~may~~ invite family members, friends, DDA advocacy specialists, coworkers, professionals, and anyone else in their circle of support that they desire to be part of person-centered planning team meetings. The participant is encouraged to involve important people in their life in the planning process. However, the participant and their legally authorized representative, (as applicable) ~~or their legal guardian or authorized representative(s) (if applicable)~~, also retains the authority to exclude any individual from participating in the development of their Person-Centered Plan with the Coordinator of Community Services.

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d. **i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Development of the Person-Centered Plan

Who Develops?

The participant directs the development of their Person-Centered Plan.

The Coordinator of Community Services is responsible for the development

of the ~~PCP~~ Person-Centered Plan with the participant and their legally authorized representative, (as applicable) ~~their legal guardian or authorized representative(s) (if applicable)~~, and their chosen team. The participant and their legally authorized representative, (as applicable) ~~along with their legal guardian or authorized representative(s) (if applicable)~~, is the primary contributor to the plan and may receive support from other persons selected by the participant in developing the plan. The Coordinator of Community Services facilitates the planning process.

Participants can use a variety of person-centered planning methodologies such as the Charting the LifeCourse (i.e., Integrated Support Star, Life Trajectory, and Exploring Life Possibilities), Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy.

Who Participates?

The participant directs the development of their Person-Centered Plan.

As further specified in subsection d. above, the participant, and their legally authorized representative, (as applicable) ~~their legal guardian or authorized representative(s) (if applicable)~~ ~~and chosen family members~~ are the central members of the team responsible for planning and developing a ~~PCP~~ Person-Centered Plan. The participant~~,~~ and their legally authorized representative, (as applicable) ~~legal guardian or authorized representative(s) (if applicable~~) on the participant's behalf, may invite others important to the participant to be part of the planning process, including the participant's staff and providers. However, the participant and their legally authorized representative, (as applicable) ~~or their legal guardian or authorized representative(s) (if applicable), also~~ retains ~~retain~~ the authority to exclude any participant from development of their Person-Centered Plan with the Coordinator of Community Services. The participant and their legally authorized representative, (as applicable), ~~or their legal guardian (if applicable),~~ indicates their agreement with the Person-Centered Plan by signing a Signature page that can be in writing or ~~via electronic means~~ electronically as per DDA policy.

Participants may also seek support with decision making from ~~a specific person or a team of~~ other individuals. Supported decision making means a process by which an adult, with or without having entered a supported

decision–making agreement, utilizes support from a series of relationships in order to make, communicate, or put into action the adult's own life decisions.

Timing of Plan

The initial plan is developed as part of the Medicaid waiver ~~Waiver~~ program application process and updated within 365 days of the annual plan date ~~annually~~, or more frequently when there are changes to the participant's circumstances or services.

The ~~CCS~~ Coordinator of Community Services contacts the participant and their legally authorized representative, (as applicable), ~~and their legal guardian or authorized representative(s) (if applicable),~~ to obtain the participant's preferences for the best time and location of the planning meeting. Meetings may be held at the participant's home, job, a community site, day program, virtually, or wherever they feel most comfortable reviewing and discussing their plan.

(b) Types of Assessments Conducted to Support Development of the Person-Centered Plan

In addition to obtaining a variety of information and assessments about the participant's needs, preferences, life outcomes, and health from other sources as specified below, the Coordinator of Community Services uses the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS)®.

The Health Risk Screening Tool assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant.

The Support Intensity Scale measures the participant's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports the participant requires.

In addition to these assessments, the Coordinator of Community Services gathers information regarding the participant's needs, outcomes, and

preferences from the participant, their family, friends, and any other individuals ~~participants~~ invited to participate in the planning process. The Coordinator of Community Services also reviews other formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., Speech Pathologist, Occupational Therapist, Physical Therapist), as appropriate.

(c) Provision of Information Regarding Available Waiver Program Services to the Participant

During initial meetings, quarterly monitoring activities, and the annual ~~PCP~~ Person-Centered Plan development meeting, the ~~CCS~~ Coordinator of Community Services shares information with the participant and their legally authorized representative, (as applicable), ~~and their legal guardian, or authorized representative(s) (if applicable)~~ about available Medicaid ~~W~~waiver program services, as well as local county resources and services, community resources, generic resources, natural supports, and services available through other programs, Medicaid State Plan services, and qualified providers (e.g., individuals, community-based service agencies, vendors, and entities). The ~~CCS~~ Coordinator of Community Services also provides information on how to access~~, via the internet,~~ a comprehensive list of DDA services ~~(including all Waiver program covered services)~~ and DDA providers. The ~~CCS~~ Coordinator of Community Services assists the participant in integrating the delivery of support ~~supports~~ needed. ~~If the participant does not have internet access, the CCS provides the participant with a hard-copy resource manual.~~

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

The DDA requires each ~~CCS~~ Coordinator of Community Services and provider to use a participant-directed, person-centered planning approach. This approach identifies the participant's strengths, assets, and those things that are both Important To and Important For, as well as needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for a ~~PCP~~ Person-Centered Plan. As part of this person-centered planning approach, the ~~CCS~~ Coordinator of Community Services gathers information from the participant and their legally authorized representative, (as applicable), ~~their legal guardian, or authorized representative(s) (if applicable)~~, their circle of support (family

and friends), assessments~~,~~ and observations~~, and interviews.~~

Based on a person-centered planning approach, a ~~PCP~~ Person-Centered Plan is developed. The ~~PCP~~ Person-Centered Plan identifies supports and services to meet the participant's needs, outcomes, and preferences ~~in order for them to~~ so they may live in their home or community and whether those supports and services will be provided by natural or informal supports, other local, State, and federal programs, or this Medicaid waiver ~~Waiver~~ program. Skills to be developed or maintained under Medicaid waiver ~~Waiver~~ program services are determined based on the individualized goals and outcomes as documented in their ~~PCP~~ Person-Centered Plan. The ~~PCP~~ Person-Centered Plan will also address any need for training for the participant and their legally authorized representative, (as applicable), ~~their legal guardian or authorized representative(s) (if applicable)~~ family member(s), and provider or direct care staff in implementing the ~~PCP~~ Person-Centered Plan.

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

(e) How Waiver and Other Services are Coordinated

The ~~CCS~~ Coordinator of Community Services assists the participant ~~and the team~~ in coordinating local community services, generic resources, natural supports, services available through other programs, Medicaid State Plan services, and Medicaid waiver ~~Waiver~~ program services. The~~CCS~~ Coordinator of Community Services provides case management services, including assisting the participant to connect with this array of services and supports and ensures their coordination.

The ~~PCP~~ Person-Centered Plan is the focal point for coordinating services available under various programs, including this Waiver program. It reflects who the person is and the ~~those~~ things that are important To and For them, and identifies their needs, goals, interests, and preferences for ~~related to~~ achieving their desired lifestyle. The Coordinator of Community Services assists the participant in exploring assistive technology to obtain an independent lifestyle. The ~~PCP~~ Person-Centered Plan serves as a working plan that addresses the participant's specific needs, with a focus on the participant having control over their services and supports while working towards achieving and maintaining a good quality of life, well–being, and informed choice, in accordance with the participant's goals related to social life, career, spirituality, citizenship, advocacy, and preferences. The ~~PCP~~ Person-Centered Plan includes focus areas that participants can explore related to employment, communication, life-long learning, community involvement, day-to-day life, finance, home and housing, health and wellness, and relationships ~~goals~~.

(f) How the Development Process Provides for the Assignment of Responsibilities to Implement and Monitor the Plan

In general, the Person-Centered Plan outlines roles and responsibilities for services and supports.

The Coordinator of Community Services is responsible for monitoring the implementation of the Person-Centered Plan on an ongoing basis ~~and, at a minimum,~~. 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. ~~quarterly basis through telephone, e-mail, and face-to-face contacts.~~ The ~~CCS~~ Coordinator of Community Services also monitors that the services and supports meet the participant's health and safety needs and that the participants remain satisfied with their services and supports as identified in their approved Person-Centered Plan.

In addition, when a change in health status occurs or an incident is reported, the ~~CCS~~ Coordinator of Community Services facilitates the evaluation of the participant's service needs to address the change, if appropriate. The ~~CCS~~ Coordinator of Community Services also monitors

that services are delivered in the manner described in the ~~PCP~~ Person-Centered Plan, and that the participant's outcomes, needs, and preferences, as identified in the ~~PCP~~ Person-Centered Plan, are being addressed and met during their quarterly reviews and on an annual basis.

(g) How or When the Plan is Updated

At least annually, or more frequently when there is a change in a participant's needs, health status, or circumstances, the participant and their legally authorized representative, (as applicable), ~~their legal guardian, or authorized representative(s) (if applicable),~~ and their self-selected person-centered planning team must come together to review and revise the ~~PCP~~ Person-Centered Plan. This process must be facilitated by the ~~CCS~~ Coordinator of Community Services. These required updates to a participant's ~~PCP~~ Person-Centered Plan ensure that it reflects the current needs, preferences, and outcomes of the participant.

The ~~PCP~~ Person-Centered Plan is updated in accordance with the person-centered planning process identified in this subsection d.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ 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.

☒ For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

☒ A specific and individualized assessed need for the modification.

☒ Positive interventions and supports used prior to any modifications to the person-centered service plan.

☒ Less intrusive methods of meeting the need that have been tried but did not work.

☒ A clear description of the condition that is directly proportionate to the specific assessed need.

☒ Regular collection and review of data to measure the

ongoing effectiveness of the modification.

☒ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

☒ An assurance that interventions and supports will cause no harm to the individual.

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e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk Assessment

During development of the ~~PCP~~ Person-Centered Plan, the participant's planning team, facilitated by the ~~CCS~~ Coordinator of Community Services, assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance of the participant. In addition to objective assessments, the family can be a key source of information on risk assessment and mitigation, especially when supporting participants under the age of 21.

To promote optimum health, to mitigate or eliminate identified risks, and to avert ~~unnecessary~~ health complications or deaths, the ~~CCS~~ Coordinator of Community Services must complete the electronic ~~HRST~~ Health Risk Screening Tool for all participants annually as part of the ~~PCP~~ Person-Centered Plan planning process. The ~~HRST~~ Health Risk Screening Tool is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable,

field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the participant. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once a participant is fully screened, the ~~HRST~~ Health Risk Screening Tool produces Service and Training Considerations that can be used by staff and families. Service and Training Considerations describe what further evaluations, specialists, assessments, or clinical interventions may be needed to support the participant based on the identified health risks.

Participants with an ~~HRST~~ Health Risk Screening Tool level score of 3 or higher are considered higher risk thus requiring ~~require~~ increased monitoring and supervision by their health care professionals and service provider (as applicable). If a participant's ~~HRST~~ Health Risk Screening Tool Health Care Level becomes a score of 3 or higher, a Registered Nurse must complete a Clinical Review of the ~~HRST~~ Health Risk Screening Tool as per the standard process with this national tool. (Note: The Registered Nurse must complete training and be certified as a ~~HRST~~ Health Risk Screening Tool Reviewer in order to maintain the validity and reliability of the tool.) The ~~HRST~~ Health Risk Screening Tool contains a comments section where the ~~CCS~~ Coordinator of Community Services (the ~~HRST~~ Health Risk Screening Tool Rater) can give reasons for why a score was selected. This will allow the certified Nurse "~~HRST~~ Health Risk Screening Tool Reviewer", to evaluate the appropriateness of the score. The Nurse (~~HRST~~ Health Risk Screening ToolReviewer) performs ~~interviews and~~ record reviews and may perform interviews to validate each ~~HRST~~ Health Risk Screening Tool rating and score computation. All clarifying information about a rating area entered by the Nurse (~~HRST~~ Health Risk Screening Tool Reviewer) is written in the "Comments" section for the appropriate item. The Nurse (~~HRST~~ Health Risk Screening Tool Reviewer) also reviews and can add comments ~~revises~~ as necessary, for the Evaluation/Service and Training Recommendations.

In addition to medical concerns, the participant, family, and other team members can identify other areas of risk using the 'Charting the LifeCourse' framework, such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports.

Risk Mitigation Strategies

After these risk assessments are completed and reviewed, potential risk mitigation strategies are discussed as part of the team meeting, are based on the unique needs of the participant, and their family, and must ensure health and safety while affording a participant the dignity of risk. The ~~CCS~~ Coordinator of Community Services assists the participant and their team in the development of these risk mitigation strategies including back-up plans and emergency plans, which are incorporated into the ~~PCP and~~ service record.

Once identified, the ~~CCS~~ Coordinator of Community Services will incorporate individualized risk mitigation strategies, including back–up plans and emergency plans into the ~~PCP~~ Person-Centered Plan, in accordance with the participant's and their family's needs, goals, and preferences. Risk mitigation strategies may include: (1) participant, family, and staff training; (2) Assistive Technology; (3) back-up staffing plans; (4) emergency management strategies for various risks such as complex medical conditions, identified elopement risk, or previous victim of abuse, neglect, and exploitation; and (5) other strategies as identified through an approved Behavior Support Plan or Nursing Care Plan.

In addition, all participants ~~(regardless of service delivery model)~~, and Medicaid ~~DDA licensed and certified~~ service providers must have a system for providing emergency back-up services and supports as part of their service plan, policies, and procedures, which are reviewed by the DDA and ~~OHCQ~~ Office of Health Care Quality. Emergency back-up plans are reviewed by the ~~CCS~~ Coordinator of Community Services during quarterly monitoring to ensure strategies continue to meet the needs of the participant.

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f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The ~~CCS~~ Coordinator of Community Services provides information to each participant and their legally authorized representative, (as applicable), ~~their legal guardian or authorized representative,~~ and other identified planning team members regarding available Medicaid waiver ~~Waiver~~ program services~~, service delivery models (i.e., Self-Directed Services and Traditional Service Delivery Model)~~, ~~and~~ qualified providers, and availability of service providers. The ~~CCS~~ Coordinator of Community Services assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, outcomes, and preferences.

~~For participants choosing the Self-Directed Services Delivery Model, the Coordinator of Community Services informs the participant of their options under the employer authority to identify and select their staff and service providers.~~

~~For participants choosing the Services delivery model, t~~The ~~CCS~~ Coordinator of Community Services informs the participant of available DDA-licensed and approved ~~certified~~ providers. The participant, and their legal guardian or authorized representative (if applicable), may explore, interview, and exercise choice regarding these potential providers. The ~~CCS~~ Coordinator of Community Services assists the participant in scheduling visits with providers and provides a list of providers from which they may make informed choices (including the DDA's website).

The ~~CCS~~ Coordinator of Community Services and the DDA encourages participants to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency. Potential providers can discuss how they can support the participant and their family in a way that meets the participant's needs, outcomes, and preferences related to achieving the participant's desired lifestyle.

For services and programs at a specific location, participants and their families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

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g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The ~~OLTSS~~ Office of Long Term Services and Supports ensures compliant performance of this waiver by delegating specific responsibilities to the Operating State Agency, the DDA, ~~(the DDA)~~ through an Interagency Agreement ~~(IA)~~.

All Person-Centered Plans of participants entering the waiver are submitted to the DDA for review prior to service initiation. The DDA reviews the Person-Centered Plans and supporting documentation to ensure ~~assure~~ compliance with all policy and regulations. Changes to services (amount, duration, scope) in a ~~PCP~~ Person-Centered Plan (through the annual process or due to a change in a participant's needs) must be submitted to the DDA for review and approval ~~as per policy and guidance~~.

A mandatory DDA self-directed orientation/training is required for all new applicants and participants using the Provider Managed Service Delivery Model interested in the self-directed service delivery model in order for the plan to be approved. The training is to:

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

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

There is no cost to participants to attend.

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. If not completed by March 31, 2026, the participant will be transitioned to the Provider-Managed Service Delivery Model.

~~PCP~~ Person-Centered Plans are also reviewed during:
1. DDA site visits related to incident reports and health and welfare concerns; ~~, Quality Improvement Organization,~~ and
2. The ~~OLTSS~~ Office of Health Care Quality surveys to ensure they are

current and comply with ~~all Waiver eligibility, fiscal and programmatic~~ regulations and during complaints and incident investigations.

In addition, a representative sample of Person-Centered Plans are reviewed by the Quality Improvement Organization.

The Person-Centered Plans are maintained in the Maryland's Long-Term Services and Supports (LTSS*Maryland*) System. Records are maintained for 7 years.

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h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

☐ Every three months or more frequently when necessary

☐ Every six months or more frequently when necessary

☒ Every twelve months or more frequently when necessary

☐ Other schedule

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid Agency**

☐ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

LTSS*Maryland* retains copies of the Person-Centered Plans. Information is retained in LTSS*Maryland* under the Programs > POS/PCP/POC module. The LTSS*Maryland* system currently maintains the full history of documents.

Appendix D: Participant-Centered Planning and Service Delivery D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

State staff and Maryland Department of Health agents will conduct site visits, perform utilization reviews, and follow up on health and welfare concerns. In-person health, welfare, and service monitoring visits from Coordinators of Community Services and Maryland Department of Health staff assess the participant's services and health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance of the participant.

(a) The Entity (Entities) Responsible For Monitoring Implementation of Service Plan and Participant Health & Welfare

The Coordinator of Community Services and the DDA monitor the implementation of the Person-Centered Plan to ensure that Waiver program services are delivered in accordance with the Person-Centered Plan and consistent with safeguarding the participants' health and welfare.

Access to non-waiver services:

The person-centered planning process includes the exploration and

discovery of important relationships, community connections, faith-based associations, health needs, areas of interest, and talents that can also help ~~to~~ identify additional potential support for desired ~~O~~outcomes.

The ~~PCP~~ Person-Centered Plan Outcome page in LTSS*Maryland* includes a description of how community resources and natural supports (i.e., non-Waiver services) are being used or developed. The Coordinator of Community Services Person-Centered Plan Guide ~~guide~~ provides direction for the ~~CCS~~ Coordinator of Community Services on how to identify and describe opportunities for people to utilize their natural supports, including non-staff supports to engage in the Outcome-related activities and to include use of generic community resources (e.g., using a store-provided shopping aide or having staff focus on developing relationships with coworkers ~~coworker's~~ versus providing actual on-the-job assistance). All natural, community, and other contributing resources to support the outcome are listed under the Supports Considerations chart of the Outcome section. ~~Supports identified are then noted with the Support Considerations chart that include the name of the person, relationship, support/service, and support role.~~

In addition, Community Living–Group Home and Community Living–Enhanced Support services are delivered by provider-owned or leased ~~provider-owned~~ and operated residential habilitation sites. These providers are responsible for supporting the participant to attend their health appointments and for follow-up actions based on results and the documentation of said events. This information must be provided to the Coordinator of Community Services.

(b) Methods for Monitoring and Follow-Up Activities

The ~~PCP~~ Person-Centered Plan format based in LTSS*Maryland* also includes information related to how the team will know that progress is occurring and the frequency for assessing satisfaction, the implementation strategies, and reviewing the outcome.

The ~~CCS~~ Coordinator of Community Services is required to conduct quarterly monitoring and enter information into the ~~an enhanced~~ LTSS*Maryland* ~~-based~~ Monitoring and Follow-Up form. The form includes sections related to demographic information, contacts, date of visit, any changes in status, service provision, participant satisfaction, progress of outcomes, and health and safety. Based on data entry in these sections, follow-up action may be required and will be noted in the "Recommended

Action" section which can include items specific to service provision. Health and safety items require immediate action and, in some situations, require an incident report as per the Policy on Reportable Incidents and Investigations which is described in Appendix G.

The ~~CCS~~ Coordinator of Community Services's monitoring activities are designed to provide support to participants and their families and encourage ~~encourages~~ frequent communication to address current needs and to ensure health and safety. In addition, monitoring facilitates increased support to plan for services throughout the participant's lifespan. The monitoring maximizes support to create the quality of life envisioned by the participant and the family.

The ~~CCS~~ Coordinator of Community Services's monitoring activities verify that the participant is receiving the appropriate type, amount, scope, duration, and frequency of services to address the participant's assessed needs and desired outcome statements as documented in the approved ~~and authorized and authorized PCP~~ Person-Centered Plan. It also ensures that the participant has access to services, has a current back-up plan, including an emergency plan, and exercises free choice of providers. When changes in a participant's needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increased monitoring may be warranted based on participant's health and safety needs.

The ~~CCS~~ Coordinator of Community Services conducts these monitoring and follow-up activities through multiple and various sources, not limited to, service and environmental observation, LTSS*Maryland* service reports, incident reports, provider training and activity logs, and through conversations ~~means including telephone conferences, emails, virtual meetings, and face-to-face meetings~~ with the participant, their legally authorized representative, (as applicable), ~~their legal guardian or authorized representative (if applicable), and~~ other identified planning team members, and service providers. The Coordinator of Community Services is required to conduct an in-person, face-to-face, visit with the participant enrolled in services at least once per quarter as per DDA requirements.

The ~~CCS~~ Coordinator of Community Services must enter information regarding these monitoring activities and follow-up actions into the LTSS*Maryland* Monitoring and Follow-Up form~~, on a standardized form required by the DDA, information regarding these monitoring activities and follow-up actions.~~ Health and safety concerns must be reported per the

Policy of Reportable Incidents and Investigations and included in the Monitoring and Follow-Up form. ~~requirements directly to the DDA via communication with the DDA Regional Office and/or incident reporting as per required by the PORII.~~

The DDA monitoring activities include:

1. Regional Offices monitoring implementation of the Person-Centered Plan through the review and approval of service plans and authorizations of services revisions are made to address changing needs of the participants;

2. Regional Offices conducting onsite reviews of participant services and providers implementation including elements related to staff knowledge of services, service delivery as noted in the Person-Centered Plan, and health and welfare (e.g., medication administration records and health assessments completed); and

3. Regional Offices monitoring the quality of the ~~CCS~~ Coordinator of Community Services monitoring services related to the implementation of the service plan.

To oversee and assess ~~CCS~~ Coordinator of Community Services activities, ~~CCS required quarterly~~ ~~m~~Monitoring and Follow-Up ~~follow up~~ forms are automated in the LTSS*Maryland* system and are required to be completed by the Coordinator of Community Services. The DDA has implemented a ~~CCS~~ Coordinator of Community Services squad within each regional office who are responsible for providing technical assistance and oversight to ~~CCS~~ Coordinator of Community Services agencies. ~~Most recently the~~ The DDA has also contracted with a Quality Improvement Organization to facilitate ~~CCS~~ Coordinator of Community Services billing audits and quality assurance reviews of Person-Centered Plans ~~Plan's~~ and monitoring and follow-up ~~/follow up~~. These audits and quality assurance reviews will result in a Plan of Correction ~~(POC)~~, as applicable. The Quality Improvement Organization ~~DDA RO~~ will ensure any Plan of Correction ~~POC~~ is completed and satisfied.

The LTSS*Maryland* Monitoring and Follow-Up ~~Form~~ Report provides both the DDA and ~~CCS~~ Coordinator of Community Services agencies information related to ~~review related to~~ the completion status of the Quarterly Monitoring and Follow-up forms for each person served. This functionality enables the DDA to improve its oversight and review of ~~CCS~~ Coordinator of Community Services activities. The DDA regional offices and Headquarter

~~CCS~~ Coordinator of Community Services leadership regularly meet with each ~~CCS~~ Coordinator of Community Services provider ~~agency~~ to review applicable data related to the completion and timely submission of Person-Centered Plans ~~Plan's~~ and ~~M~~monitoring and Follow-up form ~~/follow up~~. The Regional Offices are tracking and monitoring ~~PCPs~~ Person-Centered Plan and monitoring and follow-up completion on a weekly basis and following up with applicable ~~CCS~~ Coordinator of Community Services agencies as necessary.

Each ~~CCS~~ Coordinator of Community Services will review evidence of satisfaction with services ~~support~~, service goal implementation, ensure the person is healthy and safe ~~safety needs~~, and if there are any changes in a person's need, such as support with maintaining Medicaid eligibility. This must be documented in LTSS*Maryland*'s Monitoring and Follow-Up form and ~~service goal implementation and~~ include ~~document~~ whether progress has been made for people on their caseload, what they used to verify, and where the in-person visit occurred ~~occured~~. They will also review necessary documentation to verify the provision of services as authorized. If there is insufficient progress, the ~~CCS~~ Coordinator of Community Services will follow-up with the service provider to determine why progress is not being made. The Coordinator of Community Services will coordinate and assess needed services and supports with the participant and their team and when applicable refer and support with any relevant natural, community, State and federal resources, services and supports.

The ~~additional the~~ Quality Improvement Organization ~~and DDA Regional Office staff~~ will also review a sample of the quarterly Monitoring and Follow-Up ~~monitoring~~ forms ~~and a reliability check will be completed during a provider visit to ensure that the documentation accurately reflects plan implementation~~. Applicable follow up with Coordinator of Community Services will occur as necessary.

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

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

The DDA's monitoring frequency include:

1. Regional Offices monitoring implementation of the ~~PCP~~ Person-Centered Plan on a periodic basis through the approval of service plans and authorizations of services revisions are made to address changing needs of the participants;

2. Regional Offices in collaboration with the Quality Improvement Organization performing onsite reviews of participant services and providers varies and includes: (a) initial or routine visits to provider sites, (b) review of a filed complaint, (c) provider Plan of Correction ~~POC~~ follow-up, (d) review of a reported incident; ~~and~~ (e) Technical Assistance; ~~and~~ (f) service request review; and

3. Regional Offices and Quality Improvement Organization monitoring the quality of the Coordinator of Community Services ~~CCNS~~ monitoring of ~~PCP~~ Person-Centered Plan implementation ~~as outlined in the monitoring policy~~.

b. **Monitoring Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

☒ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

☐ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only willing and qualified entity in a geographic area who can monitor service plan implementation. (Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation)

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

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. By checking each box, the state attests to having a process in place to ensure:

☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

☐ Direct oversight of the process or periodic evaluation by a state agency;

☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

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: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i.Sub-Assurances:

a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

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

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

Performance Measure:	Service Plan - Performance Measure 1 - The number and percentage of participants who report their service plan includes things that are important to them. ~~Number and percentage of waiver participants who have their assessed needs addressed in the service plan using waiver funded services or other means. Numerator = Number of waiver participants who have their assessed needs addressed in the service plan using waiver funded services or other means. Denominator = Number of participants reviewed.~~ Numerator = Number of participants who

	report their service plan includes things that are important to them. Denominator = Number of participants reviewed.
***Data Source (Select one) (Several options are listed in the on-line application)**: Other*	
***If 'Other' is selected, specify:** ~~Participant Record Review, and/or Quality Improvement Organization~~ National Core Indicators In-person Survey*	

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:	☒ Annually	Stratified: Describe Group:
Quality Improvement Organization	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Performance Measure:	Service Plan - Performance Measure 2 - Number and percentage of service plans that address identified risks. ~~Number and p of waiver participants who have their personal outcomes addressed in the service plan through waiver funded services or other funding sources or natural supports. Numerator = Number Number of waiver participants who have their personal~~

	~~outcomes addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator = Number of participants reviewed.~~ Numerator = Number of service plans that address identified risks. Denominator = total service plans reviewed.

Data Source (Select one) (Several options are listed in the on-line application)*: Other*
If 'Other' is selected, specify: *Participant Record Review, and/or Quality Improvement Organization Targeted Case Management 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:	Service Plan - Performance Measure 3 - Number and percentage of service plans that document exploration of other

	non-DDA services. Numerator = Number of service plans that document exploration of other non-DDA services. Denominator = total service plans reviewed.

***Data Source (Select one) (Several options are listed in the on-line application)**: Other*		
***If 'Other' is selected, specify:** Quality Improvement Organization Targeted Case Management 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: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance),

complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	Service Plan - Performance Measure ~~3~~ 4- Number and percentage of service plans reviewed and updated before the participants annual review date. ~~Percentage of service plans that document exploration of other non-DDA services.~~ ~~Numerator = Number # of service plans reviewed and updated before the waiver participant's annual review date.~~ ~~Denominator = Number of waiver service plans reviewed.~~ Numerator = Number of service plans reviewed and updated before the participants annual review date. Denominator = Number of service plans reviewed.	
Data Source (Select one) (Several options are listed in the on-line application)*: Other*		
If 'Other' is selected, specify: *Participant Record Review, and/or Quality Improvement Organization Targeted Case Management 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 95% +/-5%
☒ Other Specify: Quality Improvement Organization	☒ Annually	Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:	Service Plan - Performance Measure 5 - Number and percentage of participants who report their staff come and leave when

	they are supposed to. ~~Number and percentage of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the Person-Centered Plan. Numerator = Number. Number of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the Person-Centered Plan. Denominator = Number of participants reviewed.~~ Numerator = Number of participants who report their staff come and leave when they are supposed to. Denominator = Number of participants reviewed.

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

If 'Other' is selected, specify: *~~Participant Record Review, and/or Quality Improvement Organization~~ National Core Indicators In-person Survey*

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

	☐ Other Specify:	

d. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:	Service Plan - Performance Measure 6 - Number and percentage of participants who report they helped make their service plan. ~~Number and percentage of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator = Number of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Denominator = Total number of participants records reviewed.~~ Numerator = Number of participants who report they helped make their service plan. Denominator = Total number of participants interviewed.
Data Source (Select one) (Several options are listed in the on-line application)*: Other*	
If 'Other' is selected, specify: ~~*Participant Record Review, and/or Quality Improvement Organization*~~ *National Core Indicators In-person Survey*	

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

e. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

and how recommendations are formulated, where appropriate.

Per 2014 guidance, states no longer have to report on this sub-assurance.

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.

The DDA's Quality Enhancement staff provides oversight of planning activities and ensures compliance with this Appendix D related to waiver participants.

The DDA's ~~CCS~~ Coordination of Community Services staff provides technical assistance and support on an ongoing basis to ~~CCS~~ Coordination of Community Services providers and provides specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used, including Coordination of Community Services provider training, partnering with the DDA Provider Services staff to provide additional communication with, and training to providers. Remediation efforts will be documented in the provider's file with the DDA.

The DDA and the ~~CCS~~ Coordination of Community Services and providers report issues with LTSS*Maryland* functionality to a centralized help desk. The DDA, the ~~OLTSS~~ Office of Long Term Supports and Services, and

LTSS*Maryland* consultants meet weekly to review and prioritize system-related issues.

To improve compliance with the performance measure, the Quality Improvement Organization ~~QIO~~ will evaluate the provision of services, remediate problems with quality, design quality enhancement strategies, and deliver continuous quality enhancement for statewide services extending internal capabilities. The Quality Improvement Organization ~~QIO~~ will assess whether services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan (i.e., utilization reviews). 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 rememediation 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*(check each that applies):*

☐ **State Medicaid Agency**

☒ **Operating Agency**

☐ **Sub-State Entity**

☒ **Other** *(specify)***:**

Quality Improvement Organization

Frequency of data aggregation and analysis

(check each that applies):

☐ **Weekly**

☐ **Monthly**

☒ **Quarterly**

☒ **Annually**

☐ **Continuously and Ongoing**

☐ **Other** *(Specify):*

c. Timelines

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

☒ **No**

☐ **Yes**

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