Community Pathways Waiver

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

1. Request Information

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

B. **Program Title:**
Community Pathways Waiver

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

D. **Amendment Number:**

E. **Proposed Effective Date: 7/01/26**
Approved Effective Date:

F. **Approved Effective Date of Waiver being Amended:**

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

- Establish a **$500,000 annual budget limit (cap)** for Person-Centered Plans.
- Create a **budget cap exception process** for plans that exceed the $500,000 cap.

~~The exception process will allow approval of plans up to **$625,000** when the services are necessary to support the person's health and safety and remain within waiver service limitations.~~

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Community Pathways Waiver

	Component of the Approved Waiver	Subsection(s)
	Waiver Application	
	Appendix A – Waiver Administration and Operation	
X	Appendix B – Participant Access and Eligibility	B-1 and 2
	Appendix C – Participant Services	
	Appendix D – Participant Centered Service Planning and Delivery	
	Appendix E – Participant Direction of Services	
	Appendix F – Participant Rights	
	Appendix G – Participant Safeguards	
	Appendix H - Quality Improvement Strategy	
	Appendix I – Financial Accountability	
	Appendix J – Cost-Neutrality Demonstration	

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

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

MAIN

1. Request Information (1 of 3)

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

B. **Program Title** (optional - this title will be used to locate this waiver in the finder)

Community Pathways Waiver

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Community Pathways Waiver

C. **Type of Request: amendment**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

☐ *3 Years*

X *5 Years*

Original Base Waiver Number: MD.0023

Draft ID: ***MD.012.08.03***

D. ***Type of Waiver*** *(select only one):*

Regular Waiver

E. ***Proposed Effective Date of Waiver being Amended: 07/01/26***

Approved Effective Date of Waiver being Amended:

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

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1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

X Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities.

Select one:

X Not Applicable

☐ Applicable

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

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☐ **Waiver(s) authorized under section 1915(b) of the Act.**
Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

- **section 1915(b)(1) (mandated enrollment to managed care)**
- **section 1915(b)(2) (central broker)**
- **section 1915(b)(3) (employ cost savings to furnish additional services)**
- **section 1915(b)(4) (selective contracting/limit number of providers)**
- **section 1915(b)(4) (selective contracting/limit number of providers)**

- **A program operated under section 1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

H. **Dual Eligibility for Medicaid and Medicare.**

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

2. Brief Waiver Description

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

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

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community living, socialization, and economic self-sufficiency. The intent of services and supports are to maintain, acquire, and increase individual's independence and reduce their level of services needed.

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

As a Technology First State, our first initiative is to provide information regarding assistive technology resources as the first option of community support. Assistive technology supports and services allows Marylanders with disabilities to enhance their functional independence and support their self-defined goals.

Waiver Organizational Structure:

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

DDA utilizes various agents, licensed providers, and contractors to support administrative tasks, operations, and direct service delivery. Medicaid State Plan targeted case management services are provided by certified Coordination of Community Services provider organizations. The Maryland Department of Health's Office of Health Care Quality performs licensing, surveys, and incident investigations of many of DDA's licensed home- and community-based services providers. The Maryland Department of Health's Office of Inspector General investigates allegations of overpayment or fraud.

Participants will receive case management services, provided by DDA certified Coordination of Community Services providers, through the Medicaid State Plan targeted case management authority. Each CCS assists participants in developing a PCP, which identifies individual health and safety needs and supports that can meet those needs. The CCS is also responsible for conducting monitoring and follow-up to assess the quality-of-service implementation.

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Services are delivered under either the Self-Directed Services or Provider Managed Service Delivery Models provided by qualified providers (such as individuals, community-based service provider organizations, vendors, and other entities) throughout the State. Services are provided based on each participant's PCP, to

enhance the participant's and their family's quality of life as identified by the participant and their PCPning team through the PCPning process.

Services are provided by individuals or provider organizations (i.e., private entities and local health departments) that meet applicable requirements in Appendix C prior to rendering services. For Provider

Managed Services Delivery Model, individual providers and provider organizations are licensed or certified by the Maryland Department of Health; for the Self-Directed Services Delivery Model, the individual provider or provider organization must be certified or licensed by the Maryland Department of Health and confirmed by the FMCS provider as meeting applicable requirements. Providers offering career exploration, facility-based supports, day habilitation, licensed respite, community living-group home, and community living-enhanced supports waiver services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the participants own home such as employment services, personal supports, respite, and assistive technology and services must meet provider qualifications to be certified by DDA. FMCS providers and Support Broker services are also provided for participants that use the Self-Directed Service Delivery Model. This organizational structure provides a coordinated community-based service delivery system so that participants receive appropriate services oriented toward the goal of full integration into their community.

DDA has a contract with an entity that is certified by Centers for Medicare and Medicaid Services as a QIO to:

1. Provide strategies that enhance the quality of life and help to ensure the health and wellbeing for individuals with intellectual and developmental disabilities.

2. Develop audit standards for DDA's services including review cases and analyze patterns of services related to assessed need and quality review.

3. Conduct ongoing utilization reviews to safeguard against unnecessary utilization of care and services and to assure efficiency, economy, and quality of care.

4. Administer DDA's National Core Indicators Surveys.

Termination of Participation

A participant shall be terminated from enrollment in the Medicaid waiver program if the participant:
1. No longer meets the eligibility requirements;

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

3. Fails to use a CCS;

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

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

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

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

8. Dies.

Waiver Re-Enrollment

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

a. The individual meets eligibility requirements; and

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

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

a. During the same waiver year;

b. Within 90 days of termination; or

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

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

3. Components of the Waiver Request

The waiver application consists of the following components. ***Note: <u>Item 3-E must be completed</u>.***

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A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
E. **Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
   Yes. This waiver provides participant direction opportunities. *Appendix E is required.*
   No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
F. **Participant Rights. Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
G. **Participant Safeguards. Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
H. **Quality Improvement Strategy. Appendix H** contains the quality improvement strategy for this waiver.
I. **Financial Accountability. Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
J. **Cost-Neutrality Demonstration. Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
B. **Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:
   Not Applicable
   No
   ☒ **Yes**
C. **Statewideness.** Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

   ☒ **No**
   Yes

   If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

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Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. **Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
    1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
    2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
    3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
B. **Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
C. **Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
D. **Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
    1. Informed of any feasible alternatives under the waiver; and,

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2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H.**

I. Public Input. Describe how the state secures public input into the development of the waiver:

DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups including but are not limited to employment, self-direction, technology, supporting children and families, person-centered planning, coordination of services, training, system platforms, and rates. These partnerships provide opportunities to obtain additional information, input, and recommendations from participants that can influence services offered by this Waiver program and applicable policies and procedures.

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In 2025, DDA established the Maryland Intellectual and Developmental Disabilities Sustainability and Equity Committee (MIDSEC).

MIDSEC was created to advise and collaborate on strategies that support both the short-term and long-term financial and program sustainability of Maryland's intellectual and developmental disabilities service system.

The committee includes 22 members representing a broad range of stakeholders, including:

- Providers and participants from the Community Provider–Managed service delivery model
- Participants and family members from the Self-Directed Services model
- Representatives from Coordination of Community Services (CCS) agencies
- Support brokers
- Advocacy organizations

WAIVER AMENDMENTS ANNOUNCEMENT AND DEDICATED AMENDMENT WEBSITE

Information about the proposed budget cap was first shared on January 21, 2026, as part of the proposed DDA budget.

DDA met with the following groups to share information about the proposal:

- Developmental Disabilities Council
- Self-Directed Advocacy Network
- Concerned Citizens of Self-Direction
- Maryland Intellectual and Developmental Disabilities Sustainability and Equity Committee
- Coordination of Community Services (CCS) providers
- Financial Management and Counseling Services (FMCS) providers

DDA held a public Community Meeting on January 21, 2026 and shared the proposal.

On March 2, 2026, DDA released a public announcement about the proposed waiver amendments. The announcement was posted on the Medicaid Home and Community-Based Services (HCBS) website located at https://tinyurl.com/ykhf3mdc .

A Notice of Request for Public Comment was posted at the Maryland Department of Health and at local DDA Regional Offices.

Hard copies of the proposal are available for public review and comment. Individuals may request a copy by:

- Emailing wfb.dda@maryland.gov
- Calling DDA

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- Visiting a DDA Regional Office or MDH headquarters

Individuals may also ask their Coordinator of Community Services or service provider for help getting a hard copy.

DDA created a dedicated webpage for the Community Pathway Amendment #4 (2026) with detailed information about the proposed changes.

Track change documents are available so readers can clearly see what updates are included in the amendment. These documents are provided in both color and black-and-white versions to support accessibility, including compatibility with screen readers.

The dedicated webpage is available here:
Community Pathways Waiver – Amendment #4 (2026)
https://tinyurl.com/45edtn7m

AMENDMENT WEBINAR

DDA will host two public webinars to share information about the proposed amendment.

The webinars will be held on:

1. **Wednesday, March 4, 2026, from 12:00 – 1:30 p.m.**
   This session will provide a general overview of the proposed changes and question and answer session.

2. **Wednesday, March 11, 2026, from 12:00 – 1:30 p.m.**
   This session will provide a general overview of the proposed changes and question and answer session.

The webinar presentations and recordings will be posted on the DDA YouTube Channel and on the dedicated amendment webpage

PUBLIC COMMENT PERIOD

The official public comment period is open from **March 2, 2026, through April 1, 2026**.

The Maryland Urban Indian Organization was notified on (insert date) about the posting of this application and the start of the public comment period as part of Tribal Consultation requirements.

Public Input Summary
To be added post comment period

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the

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anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services.

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

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

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

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

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

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

Specify the transition plan for the waiver:

INDIVIDUAL BUDGET CAP

1. Information Technology Update

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To improve access and prevent over-authorization of Meaningful Day services in the provider-managed service delivery model, LTSSMaryland will be updated.

The system will be enhanced to allow authorization of 15-minute Meaningful Day services under one single "Meaningful Day" service category.

This change will:

- Simplify the authorization process
- Reduce the risk of over-authorization
- Increase timely access to Meaningful Day services based on each participant's needs

A data patch will be used to move all currently authorized Meaningful Day services into the new single service category.

LTSSMaryland is the electronic data management system used for Maryland's Medicaid Home and Community-Based Services (HCBS) programs.

2. Person-Centered Plans

All Person-Centered Plans that exceed the **$500,000 budget cap** will be reviewed.

DDA will provide technical assistance to participants and their teams. Coordinators of Community Services (CCS) will work with participants to explore ways to adjust requested services while continuing to protect the individual's health and safety.

Teams will consider how to stack, blend, braid, and sequence services across the full Medicaid system. This includes:

- Optional State Plan services, such as Rare and Expensive Case Management and Community First Choice
- Other state agency programs, such as the Maryland State Department of Education Division of Rehabilitation Services (DORS)

Throughout this process, the individual remains at the center of decision-making. Any service changes will be developed collaboratively. Each person will have meaningful input, and final decisions will reflect their goals, preferences, and path toward greater independence.

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If a Person-Centered Plan meets the individual's health and safety needs but exceeds the $500,000 budget cap, the plan will be reviewed through the budget exception process.

3. Budget Exception Process

A budget cap exception process will apply to plans that:

- Support the individual's health and safety,
- Stay within waiver service limitations, and
- Exceed the $500,000 cap~~, up to a maximum of **$625,000**~~.

To qualify for an exception, the plan must meet at least one of the following standards:

a. Behavioral Needs

The participant has a Behavior Support Plan and supporting documentation demonstrating the need for 1:1 or 2:1 staff-to-participant ratio necessary to support the person with specific behavioral needs.

b. Health Needs

The participant has a Nursing Care Plan and supporting documentation demonstrating the need for 1:1 or 2:1 staff-to-participant ratio necessary to support the person with specific health and safety needs.

c. Geographical Rate Difference

The difference between standard and geographic rates causes the plan to exceed the budget cap.

The State will adjust the $500,000 budget cap each year based on applicable annual rate changes.

Supporting Documentation

Additional documentation of assessed needs may be submitted with the plan. This may include formal health, communication, or behavioral assessments completed by qualified professionals, such as:

- Physicians
- Mental health professionals
- Behavioral specialists

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- Special educators
- Other licensed health professionals, as appropriate

A general statement or prescription that simply indicates the need for enhanced rate, overnight support or "1:1" or "2:1" staffing is not sufficient.

Supporting documentation must clearly describe:

- The individual's specific assessed needs
- The functional tasks and supports required
- The circumstances under which additional staffing is necessary
- The level of staff training or expertise needed to safely provide support

The team must also consider alternative strategies before requesting an enhanced rate, overnight support or "1:1" or "2:1" staffing, including the use of assistive or remote support technology.

4. Person-Centered Plan Decisions and Appeal Rights

After completing the review and, if applicable, the budget exception process, DDA will issue a written determination.

Individuals whose plans exceed the budget cap and those who do not meet the exception standards will receive written notice of the decision, along with information about their appeal rights.

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

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

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

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

the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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