Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age: Maximum Age Limit	Maximum Age: No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			☐
	☐	Disabled (Other)			☐
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐

Proposal

Community Pathways Waiver

	☒	**Developmental Disability**		0					☒
	☐	**Intellectual Disability**							☐
☐ **Mental Illness**									
	☐	**Mental Illness**							☐
	☐	**Serious Emotional Disturbance**							☐

b. **Additional Criteria.** The state further specifies its target group(s) as follows:

To be eligible for participation in this Medicaid Home and Community-Based Services (HCBS) Waiver program, an individual shall:

1. Have a developmental disability, as defined in § 7-101 of the Health-General Article of the Maryland Annotated Code, which is comparable to the federal definition found at 45 C.F.R. § 1325.3;

2. Meet the Level of Care provided by an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), as further described in Appendix B-6, below;

3. Meet financial eligibility requirements as set forth in this Appendix B; and

4. Meet technical eligibility requirements set forth below.

To be eligible for participation in the Medicaid waiver program, an applicant or participant must meet all of the following technical eligibility requirements:

1. The individual is a resident of the State of Maryland. This includes consideration of whether the individual meets special criteria for military families set forth in Title 7 of the Health-General Article of the Maryland Annotated Code.

2. The individual is not enrolled simultaneously as a participant in another Medicaid Home and Community-Based Services Medicaid waiver program, under the authority ofSection 1915(c) of the Social Security Act or PACE, a Maryland Medicaid capitated managed care program that includes long-term care.

3. ~~The individual does not currently reside in an institution for 30 consecutive calendar days or has a proposed date for discharge from the institution in which the individual does reside.~~The individual

does not currently reside in an institution for 30 consecutive calendar days, or resides in an institution and has a proposed date for discharge.

4. The Medicaid waiver program's services are the most appropriate and cost-effective means to meet the individual's needs without jeopardizing the health, safety, or welfare of the individual or others, including, but not limited to:

a. The individual needs services and supports when school is not in session, if the individual attends school;

b. The individual requests services that are covered by and, therefore, may be funded by the Medicaid waiver program; and

c. In combination with available natural supports, community supports, and services funded by other programs, the individual's needs can be met by the Medicaid waiver program's services such that the individual's health, safety, and welfare can be maintained in the community.

5. The individual complies 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 DDA policies including:

Participants who are still eligible to receive services through the Individuals with Disabilities Education Act shall have a portion of their daily support and supervision needs covered by the school system. The Medicaid waiver program does not provide services during school hours to avoid duplication with services required under Individuals with Disabilities Education Act; and

6. The individual must meet the eligibility criteria for waiver participation as outlined in the Medicaid waiver application and in accordance with Code of Maryland Regulations 10.22.12.11, and 10.09.24.04-1C.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

☒ **Not applicable. There is no maximum age limit.**
☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

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Appendix B: Participant Access and Eligibility B-2: Individual Cost Limit

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

☒ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

☒ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

The limit specified by the state is *(select one)*

☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

☒ **Other**

Specify:

The State will apply a $500,000 person-centered plan budget authorization cap.

A budget cap exception process will be used for plans that support health and safety within the waiver service limitations but exceed the $500,000 budget authorization cap ~~up to $625,000~~ [Removed after public input]. The exception standards are based on meeting one of the following:

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

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

3. Difference between standard and geographical rates results in the plan exceeding the

Proposal

budget cap.

The State will adjust the $500,000 Person-Centered Plan budget authorization cap based on applicable annual rate changes.

☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

☐ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

☐ **The following dollar amount:**
Specify dollar amount:

The dollar amount *(select one)*

☐ **Is adjusted each year that the waiver is in effect by applying the following formula:**
Specify the formula:

☐ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

☐ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

☐ **Other:**

Proposal

Specify:

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The application for the Medicaid waiver program requires a Person-Centered Plan. The Person-Centered Plan includes various resources and supports, in addition to Medicaid and waiver services, to support the individuals goals and health and safety.

Waiver services are authorized based on assessed need. As noted in Appendix D, a person-centered planning process is used for the development of a Person-Centered Plan. In addition to obtaining a variety of information, assessments, and supporting documentation 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).

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.

Additional support documentation demonstrating assessed needs may be submitted with the plan. This may include formal health, communication, and behavioral assessments completed by qualified professionals such as physicians, mental health professionals, behavioral specialists, special educators, and other licensed health professionals, as appropriate.

A general statement or prescription indicating the need for overnight supports, "1:1" or "2:1" staffing is not sufficient to justify the requested level of support. Supporting documentation must clearly describe the specific assessed needs of the individual, the functional tasks and supports to be provided, the circumstances under which additional staffing is required, and the level of training or expertise staff must possess to safely and effectively deliver the support. The team must consider alternative strategies to dedicate staff, including the use of technology.

Individuals whose Person-Centered Plan does not support their health and welfare are denied entrance into the program and provided appeal rights.

If the Person-Centered Plan exceeds the individual budget cap, the Coordinator of Community Services will explore with the applicant and/or representative, the exception process and ways to modify the requested services while maintaining the individual's health and welfare.

This may, for example, entail arranging for more informal supports, attending community and senior programs (as applicable), selecting a more cost effective service, and reducing service hours or reducing days of attendance at meaningful day services. However, the DDA will not approve the Person-Centered Plan if it determines that reducing services could have a detrimental impact on the

individual's health and welfare.

If an individual’s Person-Centered Plan meets their health and safety needs but the total cost exceeds the budget cap, the plan will be evaluated through the exception process.

c. **Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☒ **Other safeguard(s)**

Specify:

The Coordinator of Community Services (CCS) will work with the individual to review all service options and make sure services are provided in the most cost-effective way possible.

If adding services or hours causes costs to exceed $500,000 due to changes such as declining health or loss of unpaid supports, the individual—supported by their Coordinator of Community Services—may explore other service options. These may include different service delivery models (such as Self-Directed Services or Provider-Managed Services) or residential service options (such as Shared Living or Supported Living).

If the Person-Centered Plan exceeds the individual budget cap, the Coordinator of Community Services will explore with the applicant and/or representative, the exception process and ways to modify the requested services while maintaining the individual’s health and welfare.

~~If no solution is available within the waiver, the Coordinator of Community Services will work with the individual and their representative(s) to develop a discharge plan.~~ [Removed after public input]. If another Medicaid waiver offers more flexibility, the Coordinator of Community Services will help refer the individual to that program.

The Coordinator of Community Services may also connect the individual to:

1. Medicaid State Plan services;

2. Community resources and supports outside the waiver; and

3. The Maryland Access Point (MAP) program or another appropriate agency.

Maryland Access Point staff are knowledgeable about local community resources and can help with benefits counseling, especially if someone may lose Medicaid eligibility.

The Local Department of Social Services (LDSS) Medicaid Unit may also be involved when an individual has questions about Medicaid eligibility or needs help applying for long-term services and supports.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost- neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	16365
Year 2	16498
Year 3	20573
Year 4	20710
Year 5	21446

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*

☒ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

Proposal

☐ **The state limits the number of participants that it serves at any point in time during a waiver year.**

c. **Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

☐ **Not applicable. The state does not reserve capacity.**
☒ **The state reserves capacity for the following purpose(s).**

The purpose(s) of the reserved capacity is for:

Purposes
Crisis Resolution Waiting List Equity Fund Family Supports Waiver Participants with Increased Needs Community Supports Waiver Participants with Increased Needs Military Families Maryland State Department of Education (MSDE) Residential Age Out Department of Human Services (DHS) Foster Kids Age Out Families with Multiple Children on Waiting List Previous Waiver Participants with New Service Need End the Wait Act 2022 Money Follows the Person Emergency State Funded Conversions Transitioning Youth Psychiatric Hospital Discharge Court Involvement Deinstitutionalization

Purpose (provide a title and a short description to use for lookup):

Crisis Resolution

Purpose: The purpose of this reserved capacity category is to support individuals identified to be in the crisis resolution eligibility category who are in immediate need of services, to access needed services.

People that meet this category have been determined to meet one of the following criteria:

1. Homelessness or housing that is explicitly time-limited, with no viable non-DDA-funded alternative;
2. At serious risk of physical harm in the current environment;
3. At serious risk of causing physical harm to others in the current environment; or
4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Proposal

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and trend over time. The number of people identified for crisis resolution eligibility category has increased over time. Based on this we have projected the following slots needed for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	100
2	100
3	275
4	275
5	275

Purpose (provide a title and a short description to use for lookup):

Waiting List Equity Fund

Purpose: As per Maryland Statute, Health General Article 7-205, the Waiting List Equity Fund is to support people who are in crisis and need emergency services, individuals on the waiting list, and individuals transitioning from a State Residential Center. This category supports people transitioning from State residential centers and people on the Waiting List with the eldest caregiver.

Describe how the amount of reserved capacity was determined:

Reserved capacity is determined based on historical data and equity achieved through transitions of people leaving a State Residential Center as approved by the Maryland General Assembly.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	20
2	20
3	0
4	0
5	0

Purpose (provide a title and a short description to use for lookup):

Family Support Participants with Increased Need

Purpose: Family Supports Waiver Participant with ongoing increased needs that cannot be met within the waiver.

Describe how the amount of reserved capacity was determined:

Preview al

Based on historical data, reserved slot use for this category increased over time however, not above the projected total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

~~Year~~	**Capacity Reserved**
~~1~~	25
~~2~~	25
~~3~~	0
~~4~~	0
~~5~~	0

Purpose (provide a title and a short description to use for lookup):

Community Support Participants with Increased Need

Purpose: Community Supports Waiver Participant with ongoing increased needs that cannot be met within the waiver.

Describe how the amount of reserved capacity was determined:

Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	**Capacity Reserved**
1	50
2	50
3	0
4	0
5	0

Purpose (provide a title and a short description to use for lookup):

Military Families

Purpose: Military Families category is based on legislation (Senate Bill 563) passed during the Fiscal Year 2015 session to support individuals' reentry into services after returning to the State. It is also available to support military families who move to Maryland, once they obtain residency. The United States Department of Defense has provided information and fact sheets related to eligibility requirements and lengthy waiting lists hindering military families from obtaining supports and services for members with special needs during critical transition periods. There are national efforts to allow service members to retain their priority for receiving home and community-based services.

Describe how the amount of reserved capacity was determined:

Initial estimate assumes 10 families on the DDA Waiting List will need services. Based on historical data, this slot category has not been used. Thus, it is safe to assume it would not exceed the reserved capacity for year 1 in the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	10
2	10
3	5
4	5
5	5

Purpose (provide a title and a short description to use for lookup):

Maryland State Department of Education (MSDE) Residential Age Out

Purpose: Children supported by the Maryland State Department of Education residential services may be placed either in or out of the State of Maryland for residential support based on assessed service need. The purpose of this reserved category is to transition these individuals from the Maryland State Department of Education residential supports while they continue to receive State educational services until age 21 as per State regulation. These are individuals who are aging out of residential services under the Maryland State Department of Education. They are not in the Department of Human Services (DHS) foster care system.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on individuals that transition from the Maryland State Department of Education residential supports while they continue to receive State educational services.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	10
2	10
3	15
4	15
5	15

Purpose (provide a title and a short description to use for lookup):

Department of Human Services (DHS) Foster Kids Age Out

Purpose: Individuals within the Department of Human Services foster care system receive foster care residential supports up to the age of 18 years. At age 18, they must transition from their foster care home to other residential services and supports. The purpose of this reserved category is to transition these individuals from Department of Human Services' foster care residential supports while they continue to receive State educational services until age 21 as per State regulation.

Describe how the amount of reserved capacity was determined:

Initial reserved capacity is based on historical data on individuals from the foster care system who need residential supports.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	30
2	30
3	15
4	15
5	15

Purpose (provide a title and a short description to use for lookup):

Families with Multiple Children on Waiting List

Purpose: The purpose of this reserved capacity category is to support families seeking supports that have more than one child on the DDA Waiting List. Families may have more than one child on the waiting list that applied at different times. The children may also have different waiting list priority categories (i.e. crisis resolution, crisis prevention, or current request). This category supports the needs and stability of the entire family by providing all children on the waiting list, regardless of application date or priority category, an opportunity to apply for the waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate is based on the number of families with more than one child on the DDA Waiting List or Future Needs Registry.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	10
2	10
3	10
4	10
5	10

Purpose (provide a title and a short description to use for lookup):

Previous Waiver Participants with New Service Need

Purpose: Previously enrolled DDA waiver participants for whom the waiver service needs were met will exit the waiver. If a new service need develops at a later time, they may reapply to the waiver. There is no limit on the time period that a participant exited the Waiver in order for them to reapply. If a person was previously enrolled in the waiver, had their needs met, and then developed a new need for services, they can reapply to the waiver.

Describe how the amount of reserved capacity was determined:

Based on historical data, this number has stayed consistently below the projected total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	10
2	10
3	0
4	0
5	0

Purpose (provide a title and a short description to use for lookup):

End the Wait Act 2022

Purpose: The purpose of this reserved capacity category is to support individuals currently on the waiting list to access Waiver Services, in accordance with the End the Wait Act of 2022 (HB 1040). The law requires the Department to develop plans to reduce the DDA waitlist by 50% beginning in fiscal year 2024.

Maryland Department of Health - Waiver Programs - Waitlist and Registry Reduction (End the Wait Act) was passed by the Maryland General Assembly. It was approved by the Governor on May 16, 2022 and took effect October 1, 2022. The Maryland Department of Health submitted plans to the Governor and required legislative committee chairs. Reference: SB 636 (Chapter 464 of the Acts of 2022) - Waiver Programs - Waitlist and Registry Reduction (End the Wait Act)

The DDA's waitlist average includes approximately 4,000 individuals as of November 2022. To reduce the waitlist for the DDA-operated Medicaid waiver programs by 50%, the DDA will need to enroll 2,000 participants from the waitlist to the Medicaid waiver program over a five year period. This will result in enrollment of 400 participants annually across all three programs.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on projections for cutting the waitlist in half over the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the

waiver.

Year	Capacity Reserved
1	75
2	75
3	0
4	0
5	0

Purpose (provide a title and a short description to use for lookup):

Money Follows the Person

Purpose: As per Maryland Statute, Health General Article 15-137, reserved waiver capacity is for eligible individuals moving out of institutions under the Money Follows the Individual Accountability Act.

Describe how the amount of reserved capacity was determined:

Estimate based on transitions under the Money Follows the Person federal grant. Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	20
2	20
3	45
4	45
5	45

Purpose (provide a title and a short description to use for lookup):

Emergency

Purpose: The purpose of this reserved capacity category is to support individuals who are not on the waiting list and are unknown to the DDA, and who are in immediate crisis or other situations that threaten the life and safety of the person.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and Maryland's General Assembly approval.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved

1	50
2	50
3	10
4	10
5	10

Purpose (provide a title and a short description to use for lookup):

State Funded Conversions

Purpose: State Funded Conversions refers to individuals receiving ongoing services funded with 100 percent State general funds including previous years that participants failed to maintain their Medicaid waiver program eligibility and were disenrolled. Some individuals may leave the waiver for various reasons such as entering a hospital or rehabilitation facility to meet their needs at that time or failure to complete the financial redetermination process. The State has supported these individuals with 100 percent State General Funds for services instead of placing them on a waiting list if they do not meet any of the reserved capacity priority categories. By establishing this priority category, the State can provide additional waiver services to meet needs and maximize State General Funds to support additional individuals in the waiver.

Describe how the amount of reserved capacity was determined:

Current data reflects over 600 individuals receiving State Funding that may be Medicaid waiver eligible. Therefore, we have increased the proposed capacity to support enrollment.

Current data indicates that over 600 individuals receiving State Funding meet the Developmentally Disabled criteria. In alignment with Governor Wes Moore's government modernization initiative aimed at promoting smarter, more effective operations and saving taxpayer money, the Developmental Disabilities Administration is prioritizing the enrollment of all State-Funded DD-eligible participants into the Medicaid waiver ~~wavier~~ program. We anticipate that 394 additional individuals will complete the enrollment process within the current fiscal year which will take our current reserved slots to 600, with the remaining 300 individuals expected to finalize their enrollment in the next fiscal year. We do not anticipate additional individuals to transition out of State Funded Services

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	**Capacity Reserved**
1	200
2	206
3	300
4	0
5	0

Purpose (provide a title and a short description to use for lookup):

Transitioning Youth

Purpose: Individuals transitioning from educational services including public school system and nonpublic school placements. The purpose is to transition the most vulnerable youth from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on students transitioning and projection of individuals that may need residential services.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	150
2	150
3	850
4	850
5	850

Purpose (provide a title and a short description to use for lookup):

Psychiatric Hospital Discharge

Purpose: Individuals with developmental disabilities that transition from inpatient mental health facilities need community supports and services. Transitions from an inpatient mental health facility are not covered under the federal Money Follows the Person grant. The State has identified this group as a priority and therefore is establishing reserved capacity.

Describe how the amount of reserved capacity was determined:

Based on historical data, reserved slot use for this category has stayed consistently below the total reserved. Thus, it is safe to assume it would not go beyond the reserved capacity for the next 5 years.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	10
2	10
3	10
4	10
5	10

Purpose (provide a title and a short description to use for lookup):

Proposal

Court Involvement

Purpose: The purpose of reserved capacity is to provide community services to individuals identified through the Maryland court system.

Describe how the amount of reserved capacity was determined:

Current data show an increase in court involvement related individuals. The capacity has been increased by 5.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	15
2	15
3	20
4	20
5	20

Purpose (provide a title and a short description to use for lookup):

Deinstitutionalization

Purpose: The purpose of this reserved capacity category is to support individuals with developmental disabilities that transition from a State Residential Center or Nursing Facility to DDA services not covered under the federal Money Follows the Person.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on the number of requests received for individuals who are transitioning from State Residential Center or Nursing Facility to DDA services over the past year.

All waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Year	Capacity Reserved
1	0
2	0
3	10
4	10
5	10

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

☒ **The waiver is not subject to a phase-in or a phase-out schedule.**
☐ **The waiver is subject to a phase-in or phase-out schedule that is included in**

e. Allocation of Waiver Capacity.
Select one:

☒ **Waiver capacity is allocated/managed on a statewide basis.**
☐ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are prioritized for entrance to the waiver based on: (1) reserved capacity categories described in subsection c. above; and (2) the Waiting List priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12.

Reserved Capacity

In addition, reserved capacity is established for discrete groups of individuals as noted in subsection c above including: (1) Crisis Resolution; (2) Waiting List Equity Fund; (3) Family Supports Waiver Participants with Increased Needs; (4) Military Families; (5) Maryland State Department of Education (MSDE) Residential Age Out; (6) Department of Human Services (DHS) Foster Kids Age Out; (7) Families with Multiple Children on Waiting List; (8) Previous Waiver Participants with New Service Need; (9) End the Wait Act 2022; (10) Money Follows the Person; (11) Emergency; (12) State Funded Conversions; (13) Transitioning Youth; (14) Psychiatric Hospital Discharge; (15) Court Involvement; (16) Community Support Participants with Increased Needs; and (17) Deinstitutionalization.

Waiting List

The DDA prioritizes individuals’ placement on the Waiting List into one of three categories based on each individual’s needs: (1) Crisis Resolution; (2) Crisis Prevention; and (3) Current Request.

Crisis Resolution - To qualify for this category, the applicant must meet one or more of the following criteria.

1. Homeless or living in temporary housing with clear time-limited ability to continue to live in this setting with no viable non-DDA funded alternative;

2. At serious risk of physical harm in the current environment;

3. At serious risk of causing physical harm to others in the current environment; or

4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Crisis Prevention - To qualify for this category, the applicant:

1. Shall have been determined by the DDA to have an urgent need for services;

2. May not qualify for services based on the criteria for Category I– Crisis Resolution; and

3. Shall be at substantial risk for meeting one or more of the criteria for Crisis Resolution within 1 year, or have a caregiver who is 65 years old or more.

Current Request - To qualify for this category, the applicant shall indicate at least a current need for services.

When funding becomes available, individuals in the highest priority level of need (Crisis Resolution) receive services, followed by Crisis Prevention, and then Current Request. Determination of and criteria for each service priority category is standardized across the State as set forth in DDA's regulations and policy.

Proposed

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

Note: Complete this section prior to starting B-5: Post-Eligibility Treatment of Income

a. **1. State Classification.** The state is a *(select one)*:

☒ **§1634 State**

☐ **SSI Criteria State**

☐ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

☒ **No**

☐ **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Community Pathways Waiver

Eligibility Groups Served in the Waiver (excluding the special home and community based waiver group under 42 CFR §435.217)

☐ Parents and Other Caretaker Relatives (42 CFR § 435.110)

☒ Pregnant Women (42 CFR § 435.116)

☒ Infants and Children under Age 19 (42 CFR § 435.118)

☒ SSI recipients

☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

☒ Optional state supplement recipients

☐ Optional categorically needy aged and/or disabled individuals who have income at:
Select one:

☐ **100% of the Federal poverty level (FPL)**
☐ **% of FPL, which is lower than 100% of FPL.**
Specify percentage:

☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)

☒ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

☐ Medically needy in 209(b) States (42 CFR §435.330)

☒ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)
Specify:

Individuals aged 19 up to 65 (42 Code of Federal Regulations 435.119)
Reasonable classifications of individuals under 21 (42 Code of Federal Regulations 435.222)
Optional targeted low-income children (42 Code of Federal Regulations 435.229)
Foster care children under IV-E (42 Code of Federal Regulations 435.145)
Independent foster care adolescents (42 Code of Federal Regulations 435.226)
Children in state-subsidized adoption (42 Code of Federal Regulations 435.227)

Special home and community-based waiver group under 42 CFR §435.217)

Note: When the special home and community-based waiver group under 42 CFR §435.217 is

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included, Appendix B-5 must be completed

☐ **No.** The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

☒ **Yes.** The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217

☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

☒**A special income level equal to:**

Select one:

☒ **300% of the SSI Federal Benefit Rate (FBR)**

☐ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

☐ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

☒ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)

☐ Aged and disabled individuals who have income at: (*Select one*)

☐ **100% of FPL**

☐ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver). *Specify:*

Proposal

Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):

☒ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*

☐ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*

☐ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

b. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

☒ The following standard included under the State plan (Select one):
- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☒ The special income level for institutionalized persons (select one):
  - ☒ 300% of the SSI Federal Benefit Rate (FBR)
  - ☐ A percentage of the FBR, which is less than 300% *(Specify the percentage):*
  - ☐ A dollar amount which is less than 300%. *Specify dollar amount:*
- ☐ A percentage of the Federal poverty level *Specify percentage:*
- ☐ Other standard included under the State Plan *Specify:*

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☐ The following dollar amount *Specify dollar amount: (If this amount changes, this item will be revised.)*
☐ The following formula is used to determine the needs allowance: Specify:
☐ Other Specify

ii. Allowance for the spouse only

☒ Not Applicable
Specify the amount of the allowance
☐ SSI standard
☐ Optional State supplemental standard
☐ Medically needy income standard
☐ The following dollar amount: *Specify dollar amount: (If this amount changes, this item will be revised.)*
☐ The amount is determined using the following formula: (*Specify)*

iii. Allowance for the family

☒ Not applicable (see instructions)
☐ AFDC need standard
☐ Medically needy income standard
☐ The following dollar amount (specify dollar amount):
The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐ The amount is determined using the following formula: *(Specify)*
☐ Other (specify)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

☒ Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
☐ The State does not establish reasonable limits.
☐ The State establishes the following reasonable limits Specify: (specify)

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the

Proposal

waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

☒ The following standard included under the State plan (Select one):

☐ SSI standard

☐ Optional State supplement standard

☐ Medically needy income standard

☒ The special income level for institutionalized persons (select one):

☒ 300% of the SSI Federal Benefit Rate (FBR)

☐ A percentage of the FBR, which is less than 300% *(Specify the percentage):*

☐ A dollar amount which is less than 300%. *Specify dollar amount:*

☐ A percentage of the Federal poverty level *Specify percentage:*

☐ Other standard included under the State Plan *Specify:*

☐ The following dollar amount *Specify dollar amount: (If this amount changes, this item will be revised.)*

☐ The following formula is used to determine the needs allowance: Specify:

☐ Other Specify

ii. Allowance for the spouse only

☒ Not Applicable

Specify the amount of the allowance

☐ SSI standard

☐ Optional State supplemental standard

☐ Medically needy income standard

☐ The following dollar amount: *Specify dollar amount: (If this amount changes, this item will be revised.)*

☐ The amount is determined using the following formula: (*Specify)*

iii. Allowance for the family

☒ Not applicable (see instructions)

☐ AFDC need standard

☐ Medically needy income standard

☐ The following dollar amount (specify dollar amount):

The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

☐ The amount is determined using the following formula: *(Specify)*

☐ Other (specify)

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iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

☒ Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
☐ The State does not establish reasonable limits.
☐ The State establishes the following reasonable limits Specify: (specify)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant (select one):

☐ SSI Standard
☐ Optional State supplement standard
☐ Medically needy income standard
☒ The special income level for institutionalized persons *(Specify percentage:)*
☐ The following dollar amount: Specify dollar amount: (If this amount changes, this item will be revised.)
☐ The following formula is used to determine the needs allowance: (*Specify formula:)*

☐ Other Specify:

ii. **If the allowance for the personal needs of a waiver participant with a community spouse is**

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different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. (*Select one:)*

☒ Allowance is the same
☐ Allowance is different. *(Explanation of difference:)*

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

☒ Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
☐ The State does not establish reasonable limits.
☐ The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law)

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility
B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the

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reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

1

ii. **Frequency of services.** The state requires (select one):

☐ **The provision of waiver services at least monthly**

☒ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

183 calendar days

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

☐ **Directly by the Medicaid agency**

☐ **By the operating agency specified in Appendix A**

☒ **By an entity government agency under contract with the Medicaid agency.** *(Specify the entity:)*

Level of Care evaluations and re-evaluations are performed by each Coordinator of Community Services (CCS) with review and approval by the DDA.

☐ **Other** *(Specify:)*

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Each Coordinator of Community Services must meet the established provider qualifications for Targeted Case Management under the Medicaid State Plan and Appendix D-1.a. of this waiver.

Each Coordinator of Community Services is required to participate in in-service training on assessment and evaluation, Level of Care determination, and waiver eligibility. The Coordinator of Community Services is responsible for gathering information, including medical, psychological, and educational assessments, as part of the Level of Care determination process. The Coordinator of Community Services must be able to critically review assessments in order to make a

Proposal

recommendation to DDA regarding Level of Care.

Final decisions regarding Level of Care are made by the DDA.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All waiver participants must meet the DDA's criteria for developmental disability in accordance with Annotated Code of Maryland, Health-General Article, § 7-101, which is comparable to the federal definition found at 45 Code of Federal Regulations § 1325.3.

In order to be eligible for the Waiver, applicants must also meet the Level of Care criteria for an Intermediate Care Facilities for Individuals with Intellectual Disabilities. See 42 United States Code § 1396n(c); 42 Code of Federal Regulations §441.301(b)(1)(iii). Therefore, DDA considers the Level of Care of an Intermediate Care Facilities for Individuals with Intellectual Disabilities in its application of its statutory definition of developmental disability. In determining the Level of Care for an Intermediate Care Facilities for Individuals with Intellectual Disabilities, the DDA looks to the federal definitions of intellectual disability and related conditions, set forth in 42 Code of Federal Regulations §435.1010, as required for admission to an Intermediate Care Facilities for Individuals with Intellectual Disabilities. See 42 Code of Federal Regulations §440.150(a)(2).

The DDA requires that the Coordinator of Community Services completes a Comprehensive Assessment (CA) form based on these criteria. The Coordinator of Community Services uses the Comprehensive Assessment to make an informed recommendation to the DDA on eligibility for all individuals who apply for services. The Coordinator of Community Services submits the Comprehensive Assessment as well as any supporting documentation the Coordinator of Community Services has gathered, including professional assessments and standardized tools via LTSSMaryland for review. The Coordinator of Community Services verifies annually that the participant continues to meet the developmental disability eligibility determination.

In emergency situations, the DDA may complete the Comprehensive Assessment to determine the eligibility.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level

of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Each Coordinator of Community Services completes the initial Level of Care (LOC) evaluation and annual reviews.

Initial Evaluation

As described in subsection d. above, for the initial evaluation, the Coordinator of Community Services completes the Comprehensive Assessment and submits via LTSSMaryland, including any supporting documentation. Supporting documentation may include professional assessments such as psychological, neuropsychological, and medical evaluations, special education evaluations, behavioral rating scales, autism rating scales, evaluations conducted by speech-language, physical, and occupational therapists, and social histories.

The DDA Regional Office staff review these materials and the DDA Regional Director issues a final determination on eligibility.

In emergency situations, the DDA may complete the Comprehensive Assessment to determine the eligibility.

Annual Re-Evaluation

The Coordinator of Community Services reviews a participant's Level of Care eligibility on an annual basis, assessing whether there are any changes in status and completes the Level of Care recertification form. The DDA ensures review of all participants on an annual basis. If there are changes in a participant's status, then the Coordinator of Community Services submits a request for a reconsideration with any new supporting documentation, to the DDA Regional Office for review via LTSSMaryland.

If a participant no longer meets Level of Care or other eligibility requirements, the DDA will disenroll the participant from the Medicaid waiver program.

Failure to Meet Level of Care Requirement

If an applicant or current participant is denied eligibility for an enrollment in the waiver then they are provided a Medicaid Fair Hearing, as further specified in Appendix F.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

☐ **Every three months**

☐ **Every six months**

☒ **Every twelve months**

☐ **Other schedule**
Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

☐ **The qualifications are different.**
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

LTSSMaryland provides alerts and generates reports related to status of annual Level of Care re-evaluations, therefore ensuring that all enrolled waiver participants obtain an annual re-evaluation of their Level of Care. The Quarterly Level of Care Report includes data to reflect Level of Cares due in 90 days, 60 days, 30 days, and overdue by the Coordination of Community Services agency.

The Coordinator of Community Services completes the re-evaluation as provided in subsection f. above. The Coordinator of Community Services completes a recertification of need form and uploads into the Level of Care module in LTSSMaryland.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Information is located in the State’s information technology system - LTSSMaryland.

“LTSSMaryland” is a customized, integrated care management tracking system that manages real-time medical and service information regarding Medicaid participants.

Information is retained in LTSSMaryland under the Programs > Level of Care module.
The LTSSMaryland system currently maintains the full history of documents.

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Appendix B: Evaluation/Reevaluation of Level of Care Quality Improvement: Level of Care

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:** Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

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:	*Level of Care – Performance Measure 1 - Number and percentage of applicants who have an initial level of care completed.* *Numerator = number of applicants who have an initial level of care completed. Denominator = number of new applicants reviewed.*	
Data Source (Select one) (Several options are listed in the on-line application)*: Other*		
If 'Other' is selected, specify: *Quality Improvement Organization (QIO) Targeted Case Management Reviews*		
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)**

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

b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

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

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

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

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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:	*Level of Care – Performance Measure 2 - Number and percentage of applicants that have an initial level of care that meets Appendix B- 6 Level of Care criteria and procedure standards.* *Numerator = number of applicants that have an initial level of care that meets Appendix B- 6 Level of Care criteria and procedure standards. Denominator = number of applicants reviewed.*	
Data Source (Select one) (Several options are listed in the on-line application): *Other*		
If 'Other' is selected, specify: *Quality Improvement Organization (QIO) Targeted Case Management Reviews*		
Responsible Party for data collection/generation (check each that applies)	**Frequency of data collection/generation: (check each that applies)**	**Sampling Approach (check each that applies)**
☐ State Medicaid Agency	☐ Weekly	☐ ~~100% Review~~
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample; Confidence Interval = 95% +/-5%
☒ Other Specify: Quality Improvement Organization	☒ Annually	☐ Stratified: Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

The Quality Improvement Organization conducts Targeted Case Management Reviews and analyzes information regarding individual and systemic deficiencies. The Quality Improvement Organization shares findings with DDA and provides recommendations on 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):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: QIO	☐ **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 Level of Care that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for

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implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each individual and participant is afforded Freedom of Choice in their:

1. Selection of institutional or community-based care;
2. Selection of service delivery model (either Self-Directed or Traditional Services Models); and
3. Ability to choose from qualified providers (i.e., individuals, community-based services providers, vendors, and entities) based on service delivery model.

After an individual is determined to be eligible for the waiver, but prior to determining need for specific services or entering services, the Coordinator of Community Services informs the individual and their authorized representative (if any) of services available under both an Intermediate Care Facilities for Individuals with Intellectual Disabilities or other institutional setting and DDA’s Home and Community-Based Medicaid waiver program. The Coordinator of Community Services also provides information regarding service delivery models available under the DDA’s Medicaid waiver program. In addition, for those individuals considering the waiver, the Coordinator of Community Services provides the individual and their authorized representative with information on how to access via the internet, a comprehensive listing of DDA services and providers. If the applicant or their legal representative does not have internet access, the Coordinator of Community Services will provide a hard-copy resource manual.

Then, the individual and their authorized representative are given the choice of receiving services in either an institutional setting or home and community-based setting. This choice must be documented in the DDA’s “Freedom of Choice” Form. The Coordinator of Community Services presents and explains this form to the individual and their authorized representative and family. This form is available to the Center for Medicare and Medicaid Services upon request.

The application packet is not considered complete and the individual will not be enrolled in the waiver until the Freedom of Choice form is signed by the individual or their authorized representative, and the Coordinator of Community Services.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

LTSSMaryland retains copies of the “Freedom of Choice” form.
Information is retained in LTSSMaryland under the Programs > Application > DDA Waiver Application Packet module.
The LTSSMaryland system currently maintains the full history of documents.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the 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):

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents. All agency staff receive training in cultural competence as it relates to health care information and interpreting services.

The MDH’s website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community.

The State also provides translation services at Medicaid Fair Hearings, if necessary. If an Limited English Proficiency appellant attends a hearing without first requesting services of an interpreter, the Administrative Law Judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Proposal