Maryland
DEPARTMENT OF HEALTH

Developmental Disabilities Administration

Self-Direction Utilization and Qualified Provider Review

Standard Operating Procedure Guidance

Issue Date: 1/29/2024

Revised Date: 4/7/2025

Effective Date: 7/1/2025

All text in red indicates added/revised language since the prior release date

CONTENTS

Contents

AUDIENCE

- Liberty Healthcare Corporation staff
- Developmental Disabilities Administration (DDA) staff
- People who self-direct their services and their support teams including Support Brokers, Coordinators of Community Services, employees, providers, vendors, family members and natural supports
- Financial Management and Counseling Services providers

PURPOSE

The purpose of this guidance is to set forth applicable procedures for oversight and verification of provision of DDA funded self-directed services by qualified staff. This guidance outlines the Liberty Healthcare Corporation process to conduct utilization and qualified provider reviews of the Self-Directed Service Delivery Model. The reviews support fiscal integrity and financial accountability by evaluating compliance with Department standards related to billing, service delivery, and qualifications. Reviews also help to obtain insight into overall claims management by service category of self-directed paid claims.

DEFINITIONS

A. "Claim" is a paid amount for a service on a particular date of service, for a particular participant and particular service.

B. "Documentation requirements checklist" is a Liberty Healthcare Corporation document listing all necessary information required by service type from a Financial Management and Counseling Services provider to complete a utilization and qualified provider review.

C. "Employee" is a person who is hired and paid to provide direct support services to a participant.

D. "Financial accountability" means the assurance that payments are made only for eligible participants, for authorized services on a date of service and follow billing documentation requirements.

E. "Findings report" is the Liberty Healthcare Corporation resulting summary of findings and determinations rendered at the end of a utilization and qualified provider review. There are two types of findings reports:

   a. Initial findings report – gives Financial Management and Counseling Service provider an opportunity to submit appropriate supplemental or corrected documentation to substantiate a proper payment; and

b. Final findings report - provides the final determinations on whether a claim(s) met criteria for proper payment.

F. "Financial Management and Counseling Services provider" or "FMCS" are services provided to support a participant in the Self-Directed Services delivery model in using their budget authority and, if applicable, employer authority. Financial Management and Counseling Services include, but are not limited to:
   a. Processing claims for payment for Medicaid waiver program services in accordance with the participant's self-directed budget; and
   b. Verifying that the DDA provider, vendor, or employees meet all qualifications to provide the Medicaid waiver program service.

G. "Liberty Healthcare Corporation reviewer" is a qualified professional trained in conducting utilization and qualified provider reviews remotely and on site on behalf of Liberty Healthcare Corporation.

H. "LibertyTraks" is a web-based software application developed by Liberty Healthcare Corporation that is used to track the initiation, completion and results of each review conducted by Liberty Healthcare Corporation reviewers.

I. "LTSS*Maryland*" is an electronic data management system, developed and supported by the Department. It is used to create, review, and maintain records about:
   a. Eligibility status for services; and
   b. The participant's Person-Centered Plan, services, and funding authorized by the DDA.

J. "Participant" is an individual who is eligible to receive or is receiving DDA-funded services.

K. "Pending" means that an unmet finding can be remediated with supplemental/corrective documentation.

L. "Person-Centered Plan" is a written plan made together with the person who has a developmental disability who participates in or will participate in a Medicaid waiver program. This plan helps to the extent possible:

   a. Identify any special needs they have to stay healthy and safe;

   b. Figure out what the person wants to achieve; and

   c. Find services and providers that can help them reach their goals while being part of the community.

M. "Proxy" is someone who knows the participant's services well and supports them to participate in a participant interview.

N. "Self-directed services" means that participants, or their representative(s) if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

O. "Self-directed service providers" are support brokers, employees, vendors or DDA providers who render services to a self-directed participant for a claim.

P. "Support Broker services" are services that provide information and advice to help participants who self-direct their services to make informed decisions related to day-to-day management of employees providing services.

Q. "Utilization and qualified provider reviews" are post-payment reviews designed to ensure financial accountability of DDA paid services and ensure qualified and trained staff provided the services.

R. "Vendor" is an individual or entity contracted by the participant and paid through an Organized Health Care Delivery System to provide a service to a participant enrolled in the Self-Directed Services Model.

OVERVIEW

The Maryland Department of Health is the single state agency for Medicaid. 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 related to the operation of the Medicaid waiver programs. The Maryland Department of Health's Developmental Disabilities Administration (DDA) is the Operating State Agency and funds community-based services and supports for people with developmental disabilities. The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver programs and the state only funded programs. References: 42 Code of Federal Regulations 441.302; 42 Code of Federal Regulations 441.303; 42 Code of Federal Regulations 441.308; 45 Code of Federal Regulations 74; Service Management and Monitoring 4442.8; Service Management and Monitoring 4442.10.

The DDA has contracted with Liberty Healthcare Corporation to conduct a series of post-payment reviews (utilization and qualified provider reviews outlined below) to ensure the integrity of payments for DDA-operated Medicaid waiver programs and state only funded

services (see Appendix I Financial Accountability in the approved Waiver applications) including:

- Review of randomly selected paid claims of self-directed services;
- Review of qualifications for employees, vendors, and DDA providers who provided services for the selected paid claims.

Utilization reviews are designed to verify that the hours of service and the actual service were provided to the participant. The reviews consist of reviewing Financial Management and Counseling Services furnished documentation, DDA provider documentation as applicable, LTSS*Maryland* participant information, and required DDA forms to justify that the:

(1) Service was rendered;
(2) Support hours were utilized as described in the participant's Person-Centered Plan, service authorization in LTSS*Maryland;*
(3) Staff providing the service had the applicable training and qualifications on the date of service.

The scope of the post-payment utilization review is limited to a sampling of paid claims for services rendered during the quarterly review period from self-directed participants included in the sample. Participants included in the quarterly sample are selected through a random 95% confidence interval sampling process.

Liberty Healthcare Corporation reviewers request and review information from Financial Management and Counseling Services as part of the utilization and qualified provider reviews.

The documentation requirements include the following:

- Required documentation listed for the specific service in DDA's Guidelines for Service Authorization and Provider Billing Documentation.
- Service documentation and staff qualification and training requirements specified in DDA's Self-Directed Services Policy & Manual and federally approved Medicaid Waiver Programs.

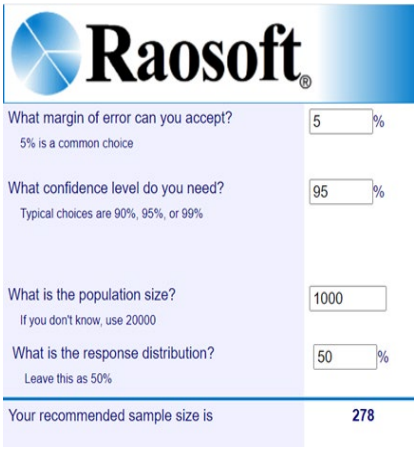
Liberty Healthcare Corporation reviewers follow a detailed process outlined below in the section titled **Self-Direction Review Process**. The process includes information related to notifications, documentation requests, findings reports and the process for participant interviews if applicable.

APPLICABILITY

This guidance applies to all information documented and uploaded into the participant's record in LTSS*Maryland* related to their Person-Centered Plan and service authorization as well as billing documentation in LTSS*Maryland*. It also pertains to the service documentation submitted to the Financial Management and Counseling Services provider for the selected claims under review. Each claim is reviewed using a detailed step-by-step instructional guide by Liberty Healthcare Corporation reviewers.

SAMPLE SELECTION PROCESS

The scope of the post-payment utilization reviews is limited to a sampling of paid claims for services rendered during the quarterly review period from self-directed participants included in Liberty Healthcare Corporation's quarterly participant sample. Participants included in the quarterly sample are based on the participant's annual Person-Centered Plan date falling within the review quarter and selected through a random 95% confidence interval sampling process.



A sampling methodology of 95% confidence interval (+/- 5% error margin), using the following automatic sampler, is used to determine the sample size for claims included in the sample (Raosoft software, http://www.raosoft.com/samplesize.html). It generates the total number of claims that must be randomly selected annually and then divided by 4 for the quarterly sample. The minimum sample size is generated when the total number of participants for the chosen review is entered into the population field.

The table below provides examples of when self-directed claims for a specific quarterly review period will be included in utilization reviews conducted by Liberty Healthcare Corporation. The first row provides dates to transition samples and review periods to a new cycle for more recent data. The following rows demonstrate examples of the continued review cycle.

Quarterly Review Period [Dates of Paid Claims]	Liberty Reviewers will Conduct Utilization & Qualified Provider Reviews
January 1, 2025 – June 30, 2025	August 1, 2025 – October 31, 2025

July 1, 2025 - September 30, 2025	November 1, 2025 - January 31, 2026
October 1, 2025 - December 31, 2025	February 1, 2026 - April 30, 2026

SELF- DIRECTION REVIEW PROCESS

PRE-REVIEW ACTIVITIES:

Step 1: Quarterly claim sample is pulled and uploaded into LibertyTraks.

Step 2: Claims are assigned to Liberty Healthcare Corporation reviewers. The reviewer accesses the case and builds the record in preparation for the review. For all cases, this includes demographics of the participant captured from data imports (e.g., imports from LTSS*Maryland*) or from previous reviews.

Step 3: During the first week of each quarterly review period, the reviewer sends a secure email notification to the primary contact at the Financial Management and Counseling Services provider informing them of the review of the specified claim(s), which includes the date of service, service type, and participant who received the service. The reviewer requests required service documentation, as well as, staff training, and qualification documentation. The email notification requests confirmation of receipt. If confirmation is not received within three (3) business days, the reviewer calls the Financial Management and Counseling Services to verify primary contact information.

The email notification for Financial Management and Counseling Services providers list the documents needed to complete the review, which includes:

- Required documentation listed for the specific service in DDA's Guidelines for Service Authorization and Provider Billing Documentation.
- Service documentation and staff qualification and training requirements specified in DDA's Self-Directed Services Policy & Manual and federally approved Medicaid Waiver Programs.

UTILIZATION REVIEW ACTIVITIES:

Step 1: Financial Management and Counseling Services provider have fifteen (15) business days to respond to documentation requests. LibertyTraks provides reviewers with alerts of when documentation is due. If a Financial Management and Counseling Service provider fails to submit requested documentation, the review will be initiated with the documentation that is available in LTSS*Maryland*.

Step 2: The Liberty Healthcare Corporation Lead Reviewer uploads documentation submitted by the Financial Management and Counseling Service provider to LibertyTraks within three (3) business days of receiving it. Reviewers begin reviews in the order they receive requested documentation and complete reviews within three (3) business days of starting a review. All initial reviews are completed by week eight (8) of the quarterly review process. Results are communicated to Financial Management and Counseling Services providers after all initial reviews are completed.

Step 3: Reviewers complete initial reviews to determine if the services outlined in the participant's Person-Centered Plan have been delivered, documented, billed, and paid as required, as well as provided by qualified employees, vendors and/or providers. **See attached Appendix B: Indicator Questions/Authority Table**.

Step 4: Quality control checks on at least 10% of reviews are conducted by Liberty Healthcare Corporation supervisors to ensure each step of the review was conducted as outlined in the instructional guide. Assignment of cases for quality control checks are randomly selected at the time the sample is loaded into LibertyTraks. Follow-up coaching and training is provided to reviewers not meeting an 85% or higher accuracy threshold. Findings are adjusted accordingly to accurately reflect the correct finding and evidence.

Step 5: Initial findings reports are generated from LibertyTraks and sent via secure email to Financial Management and Counseling Services providers. Met and unmet findings are included in the initial findings report.

A. Unmet findings consist of:
    a. Less services provided than billed;
    b. Services provided did not match the definition of the services billed;
    c. Payments cannot be substantiated by appropriate service record documentation;

d. Required staff training could not be verified prior to service delivery;
e. Required staff qualifications could not be verified prior to service delivery.

B. The initial finding report is sent in week nine (9) of the quarterly review period.
C. If unmet findings are identified in the initial review, the Financial Management and Counseling Services' initial findings report will highlight each unmet finding, indicating which claims are "pending remediation" and request supplemental/corrective documentation to remediate the unmet finding.
D. It is recommended that the FMCS schedule a meeting with Liberty Healthcare Corporation by week 9 of the review period to review unmet findings and required documentation to remediate findings.

Step 6: The Financial Management and Counseling Service provider has five (5) business days to provide supplemental documentation for the purposes of remediating any unmet findings highlighted in the initial findings report.

Step 7: Upon receipt of supplemental documentation from the Financial Management and Counseling Service provider, the Liberty Healthcare Corporation reviewer determines if additional documentation is acceptable. If allowable, a remediation determination is included in the final findings report.

Step 8: Final findings reports are sent via secure email to the Financial Management and Counseling Service provider within 15 business days following the end of the quarterly review period.

Step 9: Based on the extent of unmet findings, it is determined if a participant interview will be requested. The following criteria is utilized to determine if an interview with the participant and/or proxy is recommended:

- No service documentation submitted for any of the claims reviewed;
- No training and/or qualification documentation submitted for any of the claims reviewed.

The reviewer makes up to three (3) attempts to contact the participant and/or representative to request a remote or in-person interview. At least one of the contacts is through the participant's

Financial Management and Counseling Service provider if the reviewer is unable to contact the participant directly. Coordinators of Community Services and representatives listed in the participant profile in *LTSSMaryland* may also be contact to support the request for an interview. The brief (less than 30 minute) interviews are for the purpose of ensuring services are being delivered in the type, scope, amount, duration and frequency specified in the Person-Centered Plan and to better understand the potential causes of unmet findings. The information from participant interviews is used to verify review findings and support the development of further guidance and technical assistance to reduce systemic issues causing unmet findings. Liberty Healthcare Corporation reviewers are mandated reporters. Health and welfare concerns that arise from the interview are reported using DDA's Policy on Reportable Incidents and Investigations.

The reviewer obtains verbal consent from the participant or their legal guardian to conduct the interview. Interviews occur in-person or virtual based on the participants preference. If desired by the participant, family members, guardians, and important others will be included in the interview. Interviews are not conducted if the participant or their legal guardian do not consent.

The determination of whether or not a participant interview is requested is included with the final findings report. If a participant interview will not occur, the review is considered closed.

Step 10: The final findings report is sent to the point of contact of the Financial Management and Counseling Service provider within fifteen (15) business days of the end of the fiscal quarter. All final findings reports are uploaded to the google drive for review by the DDA Statewide Coordinator of Self-Directed Services, Financial Management and Counseling Services contract monitor and Quality Improvement Organization contract monitor.

Step 11: A summary of the interview(s) is completed by the reviewer and used with the final findings report to provide technical assistance to the Financial Management and Counseling Services administrative team. Technical assistance is available through an exit conference at the request of the Financial Management and Counseling Services provider and can assist in developing a corrective action plan. Exit Conference will be scheduled within five (5) business days of the completion of participant interview(s) and are conducted virtually.

Step 12: Liberty Healthcare Corporation requests the submission of a Corrective Action Plan if unmet findings remain for the following:

- Staff providing the service did not meet training and qualifications on the date of service; and/or
- The Financial Management and Counseling Services provider does not have an in-progress Corrective Action Plan request from a previous quarter for the same deficiency. In-progress Corrective Action Plan requests are Corrective Action Plans or Evidence of Implementation pending submission and/or approval within the required timeframe.

If a Corrective Action Plan is required, Liberty Healthcare Corporation notifies the Financial Management and Counseling Service provider and Quality Improvement Organization and Financial Management and Counseling Services contract monitors via email along with the issuance of the final report within 15 business days after the review period has ended.

When a Corrective Action Plan is required, the Financial Management and Counseling Service provider submits the Corrective Action Plan to the Liberty Healthcare Corporation reviewer for approval within 30 business days of the request. The Corrective Action Plan response is reviewed for accuracy and the Financial Management and Counseling Service provider receives notification of approval within 15 business days of submission to Liberty Healthcare Corporation.

If the plan is not approved, the Financial Management and Counseling Service provider receives written notification with edits required and given 15 business days to resubmit an updated Corrective Action Plan to Liberty Healthcare Corporation.

When the plan is approved, the Financial Management and Counseling Services provider receives written notification of approval and given 30 business days to submit evidence to Liberty Healthcare Corporation that the plan has been implemented. If greater than 30 business days is needed to complete evidence of implementation, Financial Management and Counseling Service providers may submit a request in writing with the Corrective Action Plan and approval will be granted at the discretion of Liberty Healthcare Corporation.

If the evidence is not approved, the Financial Management and Counseling Service provider receives written notification with edits required within 15 business days of submission. Financial

Management and Counseling Service providers have 15 business days to re-submit updated evidence.

Liberty Healthcare Corporation continues to monitor the implementation of the Corrective Action Plan until the evidence of implementation is complete. Liberty Healthcare Corporation sends, via secure email, an acceptance letter for the implemented Corrective Action Plan within 5 business days to the Financial Management and Counseling Service provider and copies the DDA Quality Improvement Organization and Financial Management and Counseling Provider contract monitors and the DDA Statewide Coordinator for Self-Directed Services.

Financial Management and Counseling Service providers who don't respond to Liberty Healthcare Corporation's Corrective Action Plan or evidence of implementation requests are reported to the Quality Improvement Organization contract monitor after three outreach attempts have been executed by Liberty Healthcare Corporation's reviewer. The Quality Improvement Organization contract monitor decides if a Corrective Action Plan will be marked as abandoned. Unresponsive providers may be subject to sanctions from the Maryland Department of Health.

If a Financial Management and Counseling Service provider has an in-progress Corrective Action Plan from a previous quarter for the same deficiency, a new Corrective Action Plan will not be issued. The provider is required to continue with the implementation of the current Corrective Action Plan.

When a Financial Management and Counseling Service provider has repeated unmet findings for the same deficiency, new strategies will be required in the Corrective Action Plan.

The Quality Improvement Organization contract monitor keeps all documents in a DDA Shared Google Drive.

CORRECTIVE ACTION TEMPLATES

Corrective Action Plan Request Summary

Baltimore Provider

Quick View Information

Main

Date:
10/02/2023

Organization Name:
Baltimore Provider

Liberty Reviewer:
Jennifer Mettrick

Reviewed Service(s):
Community Development Services Group (1-4)

Deficiencies:
Category: Policies and Procedures; Area of Deficiency: Missing documentation

Corrective Action Plan Requirements:

For each area of deficiency, create a corrective action plan that addresses the following:

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Who, by job title, and how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Acceptance of Liberty's Corrective Action Plan or submittal of a Corrective Action Plan must be returned to Liberty Healthcare by (30 business days of the exit conference)

Evidence the Corrective Action Plan has been implemented within your organization must be submitted 30 business days after approval ***an official due date will be sent once Corrective Action Plan has been approved***

Deficiency Requiring Corrective Action

Baltimore Provider

Quick View Information

Deficiency Details:

Record ID
432397

Corrective Action Category
Policies and Procedures

Area of Deficiency:
Missing documentation

Description:
Documentation did not include start and end times for the service and timesheet documentation to verify staff worked on the date of service was not submitted.

Indicator Questions Related to Deficiency:
UR1a: If applicable, was the date of service with start and end times included in service documentation?

Factors:

Possible Internal Contributing Factors:
Quality oversight process not in place for reviewing service documentation prior to billing submissions.

Possible External Contributing Factors:
Provider not receiving regular communications from DDA and was not using the Service Authorization and Billing guidance issued by DDA.

Plan

Recommended Corrective Actions:
Develop and implement a quality oversight process to review service documentation prior to billing.

Corrective Action Status
In Progress

Link to Documentation Evidence

MEDICAID FRAUD

If there are systemic or alleged **intentional** billing issues, the DDA may refer the Financial Management and Counseling Service provider, employee, vendor, DDA provider or team member to the Office Internal Audit Controls, Audit Compliance & Information Security.

APPENDIX A: COMMUNICATION

Communication is an essential component of a successful review. Below is a list of communications that are used to ensure Financial Management and Counseling Services provider and participant engagement in the review process.

Outreach			
Document	Definition/Purpose	Timing	Audience
Notification and Initial Checklist of Requested Documents	List of documents sent notifying of required documents needed to complete the review	Emailed at the start of the review. Provides a specific list of documents that are required from the Financial Management and Counseling Services provider to begin the review	Financial Management and Counseling Services
Initial Report	Communication sent with initial results of the self-directed review	Emailed mid-review if supplemental documentation is required	Financial Management and Counseling Services
Findings Report	Communication sent with finalized results of the Self-Directed Services Review(s)	Completion of the review period	Financial Management and Counseling Services

APPENDIX B: INDICATOR QUESTION/AUTHORITY TABLE

Indicator Question	Sub-Question	Justifications	Authority
Is the claim supported by documentation that services were delivered?	*** All responses to the sub questions below must be Met in order for the response to this indicator question to be Met.***		
	If applicable, was the date of service with start and end times included in service documentation?	Met = a **timesheet/invoice** with the service name, date, start and end times Unmet= any missing documentation listed above	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery Self-directed services policy and manual
	Do all service documents identify the correct participant for the claim?	Met = timesheet/ invoice with the correct participants name Unmet = documentation with missing or incorrect participants name, or no service documentation submitted	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery Self-directed services policy and manual

Indicator Question	Sub-Question	Justifications	Authority
	Was service documentation consistent with the Guidelines for Service Authorization and Provider Billing Documentation and, if applicable, Self-Directed Policy/Manual?	Met = documentation including name of staff who provided service, and a list of tasks completed OR invoice including vendor name, number of hours/units, name of staff who provided service, description of tasks completed, total amount charged AND verified service specific documentation required as part of the DDA Guidelines for Service Authorization and Provider Billing Documentation Unmet = 1 or more missing documentation requirements	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery Guidelines for Service Authorization and Provider Billing Documentation Self-directed services policy and manual

Indicator Question	Sub-Question	Justifications	Authority
	Does the timesheet/invoice confirm the staff worked on the date of service and during the time-of-service delivery (if applicable)?	Met = Electronic Visit Verification confirmed the staff worked on the date of service and during the time-of-service delivery or an Electronic Visit Verification exemption form was approved for the date of service Unmet = documentation was not submitted or did not verify date of service and time of service delivery	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery Self-directed services policy and manual
	Was the timesheet/invoice approved by the participant or their designated representative?	Met = verification timesheet/invoice of approval by the participant or designated representative as listed in the participant agreement Unmet = timesheet/invoice was not approved by anyone or was approved by someone other than the participant or designated	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery Self-directed services policy and manual

Indicator Question	Sub-Question	Justifications	Authority
		representative	
Was the person eligible on the date of service and was the service authorized in the Person- Centered Plan?	*** Both responses to the two sub questions below must be Met in order for the response to this indicator question to be Met.***		Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
	Was the person eligible on the date of service?	Met = participant was eligible on the date of service. Unmet = date of service falls outside of the eligibility span	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery
	Was the service authorized in the Person-Centered Plan?	Met = the service was authorized in the Person-Centered Plan on the date of service. Unmet = date of service falls outside of the service authorization	Home and Community-Based Services 1915 (C) Waiver Appendix D: Participant-Centered Planning and Service Delivery

Indicator Question	Sub-Question	Justifications	Authority
Was the claim coded and paid for in accordance with the reimbursement methodology specified in the approved waiver?		Met = claim was coded and paid for accurately as evidenced by use of an accurate waiver code, within the reasonable and customary rates, and billing unit, and if applicable, had an approved wage exception form. Unmet = claim was not coded and/or paid correctly	Home and Community-Based Services 1915 (C) Waiver Appendix I: Financial Accountability; Quality Improvement: Financial Accountability
Did the staff who delivered services meet all required training qualifications on the date of service?		Met = submitted documentation indicates services were delivered by trained staff on the date of service. Unmet = submitted documentation does not verify that services were delivered by trained staff on the date of service	Home and Community-Based Services 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service Self-directed services policy and manual

Indicator Question	Sub-Question	Justifications	Authority
Did the staff who delivered services meet all qualifications on the date of service?		Met = submitted documentation indicates services were delivered by qualified staff, and if applicable, qualified provider, on the date of service Unmet = submitted documentation does not verify that services were delivered by qualified staff, and if applicable, qualified provider, on the date of service	Home and Community-Based Services 1915 (C) Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service Self-directed services policy and manual

APPENDIX C: REFERENCES

RELEVANT DOCUMENTATION:

Authorized Home and Community-Based Services 1915 (C) Waivers (Appendix C, D, and I)

Self-Directed Services Comprehensive Policy

Self-Directed Services Manual

REFERENCE MATERIALS

Code of Maryland Regulations Title 10 Subtitle 22 Developmental Disabilities