Main

- **Attachment #1. Transition Plan**
  - **Nursing Supports**
    - For individuals receiving the standalone services, does the state anticipate that individuals will receive lesser amount of services now that that this is a consolidated service? Will individuals receive the same amount of service as they did when the services were standalone?
      Response: Participants will receive the same type and amount of service. The standalone services are basically moved under the umbrella of Nursing Support Services.
      CMS: Please include under Attachment #1 the state's response: *"Participants will receive the same type and amount of service.*

    - Will participants still have the choice of provider for each component (previously standalone service) or will the individual need to pick one provider to provide all components?
      Response: Participants will have the same choice of provider.
      CMS: Please include under Attachment #1 the state's response: *"Participants will have the same choice of provider."*

      *CMS recommends the following language: *"Because this is only a consolidation of three previously approved services, participants will receive the same type and amount of services and will have the same choice of providers."*

Appendix B Participant Access and Eligibility

- **Appendix B-4-a**
  - In the "Other specified groups" text box, the state has not listed out covered eligibility groups by citation as instructed by our technical guide. The state should replace the language that reads "All other mandatory and optional eligibility groups as specified in the Maryland Medicaid State Plan that meet the waiver targeting criteria" with the citations of groups covered (that are not listed in the checkboxes above the text box).
    Response: The State has added citations of groups covered.
    CMS: We request no additional information.

- **Appendix B-5-a**
  - **T**he state has indicated that it does not use spousal impoverishment rules for eligibility or post-eligibility outside of the dates that the application of these rules are mandatory. The mandatory application of spousal rules is currently set to expire on November 30, 2020 unless further extended. Please confirm that the state does not intend to apply the spousal rules past this date, which is a change from what the state selected in its prior approved waiver. If this was an intentional change, no action is necessary.
    Response: The State intends to apply the spousal rules and has checked applicable rules.
    CMS: We request no additional information.

Appendix C Participant Services

- **Appendix C-1/C-3: Various Services**
  - **Using HCBS Staff to Render Services in Institutional Settings**
    - Per the provisions in section 3715 of the Cares Act, it is only permissible for HCBS staff/Direct Support Professionals to render services in acute care settings. Please remove *"or during a short-term institutional stay, including a skilled nursing facility."* from the service definition.
      Response: As per requested, the language will be removed.
      CMS: We request no additional information.

    - **Please include the following assurance language in the service definition:**
      "*These necessary waiver services:*
      - *Must be identified in the individual's person-centered service plan;*
      - *Must be provided the meet the individual's needs and are not covered in such settings;*
      - *Should not substitute for services that the setting is obligated to provide through its condition of participation under Federal or State law, under another applicable requirement; and*
      - *Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the participant's functional abilities."*
    - Please include the following assurance language in the service definition: *"The state has mechanisms in place to prevent duplicate billing for both institutional and HCB services."*

      Response: As per requested, the language will be added.
      CMS: We request no additional information.

- **Appendix C-1/C-3: Various Services**
  - **Addition of Remote Services/Telehealth as a Service Delivery Option.**
    - Please note that CMS is still reviewing the state's proposal and will be following up with the state shortly with additional comments/guidance.
      Response: The State awaits any additional comments.
      CMS: Virtual supports as a service delivery option is still under CMS review.

CMS additional questions provided 12/11/2020

In summary, the state needs to cover the following areas. The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail.

1. Describe when this service delivery option will be utilized
2. Ensuring HIPAA compliance
3. How will this delivery option enhance the individual's integration into the community
4. Ensuring health and safety
5. Ensuring individual's rights to privacy
6. Rate methodology

Please note the State is changing the term "remote support/telehealth supports" to "virtual supports". This terminology will better describe the service delivery option and minimize confusion with the already established Community Pathways Waiver Remote Support Services.

1. **Describe when this service delivery option will be utilized**
   - Within each applicable service definition, please describe the specific situations when remote/telehealth supports will be utilized (e.g. public health emergencies, individual is unable to physically attend because of health reasons).

     Response: Virtual supports (remote/telehealth supports) can be provided at any time. However the designated waiver services that include this service model option states virtual supports may supplement in-person direct supports and may not be provided entirely this way.

     The service descriptions current list the following requirements which must be met:
     a. The remote/telehealth supports do not isolate the participant from the community or interacting with people without disabilities.
     b. The participant has other opportunities for integration in the community via the other Waiver program services the participant receives.
     c. The use of remote/telehealth supports to provide direct support has been agreed to by the participant and their team and is outlined in the Person-Centered Plan;
        i. Participants must have an informed choice between in person and remote supports;
        ii. Remote supports cannot be the only service delivery provision for a participant seeking the given service; and
        iii. Participants must affirmatively choose remote service provision over in-person supports

     As noted during the December 10, 2020, CMS's Advancing States 2020 Virtual Home and Community-Based Services (HCBS) Conference presentations titled *CMS Track—Home and Community-Based Settings Regulations: Implementation Updates and Impacts of the Public Health Emergency" related to post pandemic planning and unwinding Appendix K flexibilities, states can consider adding electronic service delivery as an option under the 1915 (c) authority.*
     - "Electronic service delivery may offer opportunities to reach participants in areas where provider capacity challenges remain. Services like career exploration, discovery and supported employment training and support could continue to be effective." (Reference slide 31)

2. **Ensuring HIPAA compliance**
   - Please describe the steps the state has taken/will take to ensure that remote/telehealth supports will comport with the HIPAA requirements as determined by the state's HIPAA officer.

     Response: As per noted in the service requirements,
     - The virtual supports must meet all federal and State requirements, policies, guidance, and regulations.

- The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information

Maryland's Medicaid Provider Agreement includes compliance with HIPAA and Maryland's Medical Record Confidentiality Act (Md. Code Ann., Health-Gen Title 4, Subtitle 3.). In addition, the Code of Maryland Regulations (COMAR) 10.22.20.10A(4) requires that licensed providers develop and adopt written policies and procedures for ensuring confidentiality for each individual in accordance with Health-General Article 7-1010, Annotated Code of Maryland.

All HIPAA violations are required to be reported to the Department's Privacy Officer. In addition, every covered entity also has its own HIPAA officer responsible for ensuring that privacy is maintained.

3. **How will this delivery option enhance the individual's integration into the community**
   Response: CMS communication noted *"The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail."* Therefore no action was taken.

4. **Ensuring health and safety**
   Response: CMS communication noted *"The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail."* Therefore no action was taken.

5. **Ensuring individual's rights to privacy**
   - Please describe in each applicable service definition how the state will ensure that individuals' rights to privacy are met, including others in the home.

   Response: As per noted in the service requirements,
   - The virtual supports must meet all federal and State requirements, policies, guidance, and regulations.
   - The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information

   Maryland's Medicaid Provider Agreement includes compliance with HIPAA and Maryland's Medical Record Confidentiality Act (Md. Code Ann., Health-Gen Title 4, Subtitle 3.). In addition, the Code of Maryland Regulations (COMAR) 10.22.20.10A(4) requires that licensed providers develop and adopt written policies and procedures for ensuring confidentiality for each individual in accordance with Health-General Article 7-1010, Annotated Code of Maryland.

6. **Rate methodology**

Response: Please see Appendix I-2-a question and response below.

Appendix I Financial Accountability

- **Appendix I-2-a Rate Determination Methods**
  The state insufficiently documented how the method of making payment for a live-in caregiver provides for the reimbursement of the participant.
  - The link (https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%20R06%%20Effective%20July%201%202016.pdf) provided for the State's rate setting methodology is no longer active. Update Appendix I-2-a to provide an updated link for the State's methodology.

    Response: The links provided in the portal is correct and active as reflected below: https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%20R06%2001%20-%20Effective%20July%201%202016.pdf

    Please note that the link noted by CMS above is missing some of the link details as highlighted in the specific area below:
    - https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%20R06%%20Effective%20July%201%202016.pdf

    CMS: The link is now active and working.

  - The State notes new productivity assumptions and wage data used to update payment rates. Verify whether the State also made changes to its employment related expenses (ERE), program support, and facility cost assumptions. If so, what data sources were used? How did updates impact payment rates?
    Response: Cost Components:
    - ERE - DDA revised the cost component based on analysis of General Ledgers submitted by Maryland providers by Optumas, which resulted in a reduction of 2.2%.
    - Program Support - DDA revised the cost component based on analysis conducted by Optumas of General Ledgers submitted by Maryland providers used by JVGA. Changes varied by service. For Community Living-Group Homes, Community Living-Enhanced Supports, and Supported Living, the cost component was reduced by 5.8%. However, the same analysis for Day Habilitation resulted in an increase of 7.1%.
    - Facility - This is only applicable to Day Habilitation. The data from the General Ledgers provided by the Maryland service providers was used to develop the rate.

    CMS: Update Appendix I-2-a with this information.

- The state proposes to add remote services/telehealth as a service delivery option for a select number of waiver services. Is there a different rate methodology for this delivery of services?
  Response: There is not a different rate methodology for the remote services/telehealth service delivery of Waiver services.
  CMS: The information provided adequately addresses the question. No further information requested.

- **Appendix I-6. Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**
  The state insufficiently documented how the method of making payment for a live-in caregiver provides for the reimbursement of the participant.
  - Per the technical guidance and waiver application instructions, the State must also detail the method used to reimburse rent and food expenses for unrelated caregivers. How does the State reimburse waiver participants for the additional costs of rent and food attributable to unrelated live-in personal caregivers?

    Response: The following language is currently noted in Appendix I- 6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver.

    Live-in Caregiver Supports is limited to the cost of rent and cost of food associated with the live-in caregiver (and not the participant), calculated as follows:

    1. The cost of rent, associated with the live-in caregiver, must be calculated as follows:
    a. The difference in cost between: (i) a unit sufficient to house the participant only; and (ii) a unit sufficient to house the participant and the live-in caregiver, providing separate bedrooms for each; and
    b. The cost must be based on, and not exceed, the Fair Market Rent for the jurisdiction in which the unit is located as determined by the Department of Housing and Urban Development.

    2. The cost of food, associated with the live-in caregiver, must be calculated as follows:
    a. The cost of food attributable solely to the live-in caregiver; and
    b. The cost must be based on, and not exceed, the U.S. Department of Agriculture's Monthly Food Plan Cost at the 2-person moderate plan level.

    CMS: We request no additional information.

Appendix J Cost Neutrality Demonstration

- **Appendix J-2-a Derivation of Estimates**
  The state updated estimates of the Number of Unduplicated Participants Served for Waiver Years 3, 4 and 5 but insufficiently documented the basis and methodology used to estimate the impact of these changes.

- The number of unduplicated participants for each service are projected to increase in general. Explain why the total number of unduplicated participants are projected to remain constant/slightly decrease. Describe the basis of unduplicated participant changes for this amendment.

  Response: The total number of slots were reduced in Yrs 3, 4, and 5 to reflect the increase in the number of Transitioning Youth enrolling in the Community Support Waiver instead of the Community Pathways Waiver.
  CMS: The information provided adequately addresses the question. Update Appendix J-2-a with the above information.

- **Appendix J-2-c.2 Derivation of Estimates**
  The State updated estimates of unit costs for Waiver Years 3, 4 and 5 but insufficiently documented the basis and methodology used to estimate the impact of these changes.
  - The State estimates that average cost per units for Supported Living (LTSSMaryland) will increase from 169 days in WY3 to 337 days in WY4. Provide an explanation for the projected increase in supported living utilization.

    Response: The average units per user for Supported Living were split between the two payment models (PCIS and LTSS) for WY3 as the transition to billing for the service in LTSS would not begin until the middle of the year. The average units per user for Supported Living in WY4 represents a full year of billing in LTSS.
    CMS: The information provided adequately addresses the question. Update Appendix J-2-c with the above information.

- **Appendix J-2-c Derivation of Estimates**
  The State updated Factor G estimate for Waiver Year 2.
  - The State updated the Factor G estimate in WY2 prior to the effective date of the amendment. Update the WY2 value so that it matches the currently approved application.

    Response: There was no change to the WY2 Factor G estimate from the currently approved application.
    CMS: Factor G for WY2 of MD.0023.R07.02 is $265,160.75. Factor G for WY2 of MD.0023.R07.05 is $264,160.75. Update the WY2 value so that it matches the currently approved application.

- **Appendix J-2-d: Estimate of Factor D**
  - **Nursing Supports**
    - The state should clarify If each component will be separately authorized in the service plan; if participants may exercise free choice of providers for each component; and if each component is billed separately, costs and expected utilization of each component must be separately identified in the Estimate of Factor D in Appendix J-2 and utilization/costs of each component service must be tracked during the period that the waiver is in effect.

Response: Each component will not be separately authorized in the Service Plan or billed separately, so estimates were only provided for Nursing Supports in Appendix J after the transition to this service.
CMS: The information provided adequately addresses the question. No further information requested.