

# Application for a 1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

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The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

The Maryland Department of Health (MDH), Office of Long Term Services and Supports (OLTSS) is adding case management as a waiver service through the Medical Day Care Services Waiver (MDCSW) and solicited providers through a competitive solicitation process. MDH offers case management as a waiver service for care coordination, plan of service development, service plan oversight, participant safeguard, authorization of waiver services, quality assurance and quality improvement activities.

During the seven (7) temporary extension periods, the OLTSS has investigated and analyzed the concern expressed by CMS regarding conflict of interest found in 42 CFR 441.301, because of the provider of service developing the plan of care. The OLTSS has met with Medical Day Care (MDC) stakeholders, sister-state operators and obtained assistance from The Hilltop Institute and the MDH Project Management Office in quantifying costs associated with the solution to add case management as a waiver service.

The implementation of case management as a waiver service will align as closely as possible with the following timeline and will be updated by way of an amendment as needed.

In order to resolve the conflict of interest within the Medical Day Care Services Waiver, the MDH will add case management as a waiver service for person-centered plan of care development; and

Tasks to be completed:

Complete a feasibility study (Hilltop); Complete a provider solicitation for case management agencies ;

Update regulations as needed;

Set the rate for the case management reimbursement; Build procedure codes specific to MDC case management;

Enhance LTSSMaryland, Maryland's data management system, to accommodate case management; Notify MDC providers of the implementation of case management;

Train MDC providers on the new processes; Select case management agencies,

Train case management agencies; and Hire and train internal staff.

- November 2024:

Switched from developing a Request for Proposal (RFP) to procuring for CMA via Competitive Solicitation (CS)

- January 2025

Developed the draft and vetted the competitive solicitation (CS). Drafted and vetted CS

- March 2025

Completed the Final version of CS. Presented for approval by leadership.

- May 2025

Created a profile on eMMA in preparation for posting the CS

- June 2025

Posted to eMMA for 90 days. Pre-solicitation conference scheduled

- August 2025

CS advertising window in eMMA closing

Prep training materials for CMA Plan of Service

- September 2025

Vendors notified of award

Schedule CMA training

- October 2025

Provider ePREP enrollment

- November 2025

Notification to providers of change of procedure

Ensure LTSSMaryland CMA functionality operational

- December 2025

Check on all affected elements

- January 2026

[Final check on all affected elements](#)

[February 2026](#)

CMA [start](#) date is [2/16/26](#)

[The MDH is also aligning the number of individuals allowed to be served in waiver years 4 and 5 to reflect enrollment trends. This will improve service utilization and expenditure reporting to federal and state partners and stakeholders.](#)

## 1. Request Information (1 of 3)

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

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

Medical Day Care Services Waiver

**C. Type of Request:** ~~Amendment~~ **New renewal**

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

☐ 3 years ☒ 5 years

**Waiver Number:** MD.0645.R03.00 Draft

**ID:** MD.011.03.00

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

Regular Waiver

**E. Proposed Effective Date:** (mm/dd/yy)

**02/01/2026** ~~07/01/23~~

**Approved Effective Date:** 07/01/23

### PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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- ☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160 Nursing Facility
- ☒ Select applicable level of care
- ☒ Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155
- If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Not applicable.

- ☐ Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140
- ☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)
- If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

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

Select one:

☒ Not applicable

☒ Applicable

Check the applicable authority or authorities:

- ☐ Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I Waiver(s) authorized under section 1915(b) of the Act.
- ☒ Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved: Submitted
- Specify the section 1915(b) authorities under which this program operates (check each that applies):
- ☐ section 1915(b)(1) (mandated enrollment to managed care) section 1915(b)(2) (central broker)
- ☐ section 1915(b)(3) (employ cost savings to furnish additional services)
- ☒ section 1915(b)(4) (selective contracting/limit number of providers)
- ☐ A program operated under section 1932(a) of the Act.
- ☐ Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐
☐

- ☐ A program authorized under section 1915(i) of the Act. A program authorized under section 1915(j) of the Act. A program authorized under section 1115 of the Act.

Specify the program:

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

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

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

**Purpose:**

The purpose of the MDCSW is to provide community eligible Medicaid participants who require a nursing facility level of care (LOC) with a cost-effective community-based alternative to institutional care. By offering the medical day care (MDC) service, the waiver can serve individuals aged 16 or older, affording them opportunities to stay connected to family and their communities. Each participant has a person-centered plan of service designed to support their health and safety while remaining cost effective to Medicaid.

**Goals of the Program are to:**

Provide [independent case management services](#), health support services, maximize optimal health functioning and independence, serve as respite/relief for families and/or caregivers, serve as an integrated service within home and community-based care, serve as rehabilitation or re-training of impaired functions, and serve as an alternative to or delay of institutional care.

**Organizational Structure:**

The Maryland Department of Health (MDH), Office of Long Term Services and Supports (OLTSS) is the single State Medicaid agency. The MDH, OLTSS, is responsible for ensuring compliance with federal and State laws and regulations related to the operation of the waiver. Additionally, MDH is responsible for policy development, authorizing and coordinating the participant and provider enrollment process, coordinating the fair hearing process, monitoring the performance of the MDC provider, overseeing the waiver and carrying out federal and State reporting functions.

Other Medicaid divisions or programs involved in the operation of the MDC Services Waiver include the Office of Systems, Operations and Pharmacy which performs functions related to provider enrollment and reimbursement of covered services through the Medicaid Management Information System (MMIS). OLTSS' Assessment Evaluation and Review Services (AERS) is a statewide mandated program located within each local health department in Maryland. AERS staff, comprised of nurses and social workers, conduct comprehensive social and medical evaluations of waiver applicants, with support from the contracted utilization control agent.

The OLTSS (SMA) monitors the case management agencies who are responsible for coordinating waiver applicants' applications and enrollment, offering/documenting applicants/participants' choice between institutional care and home and community-based services and choice among qualified providers, developing and monitoring the implementation of participants' plans of service (POS), and conducting site visits to monitor participant health, welfare, and satisfaction with services. In addition, the case managers initiate annual waiver eligibility redeterminations, ensure annual POS are completed and coordinate the denial and disenrollment processes as appropriate. The SMA or its designee are responsible for approving POS. In addition, the SMA directly monitors the activities of contracted case management agencies. The SMA or designee is responsible for receiving and reviewing Reportable Events (RE) and ensuring that there is timely and appropriate follow-up.

**Service Delivery Methods:**

The medical day care (MDC) services are rendered by MDC providers who must be licensed by the Office of Health Care Quality (OHCQ) and approved by Medicaid according to provider standards developed by the OLTSS. [Case management services are rendered by approved and enrolled case management agencies](#). All waiver services must be authorized and only those waiver services that comply with the participant's plan of service will be reimbursed by Medicaid.

## 3. Components of the Waiver Request

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**The waiver application consists of the following components.** *Note: [Item 3-E must be completed](#).*

**A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this



waiver.

- B. Participant Access and Eligibility.** **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- ☐ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☒ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the quality improvement strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- ☐ Not Applicable ☒ No
- ☐ Yes
- C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):
- ☒ No
- ☐ Yes
- If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):
- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

## 5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost- neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

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

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

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

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

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

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

**G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals:

(a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

OLTSS obtains public input for the development and operation of the MDC Services Waiver in a variety of ways. A Waiver Advisory Committee has been established to provide an ongoing forum for stakeholders to provide input to the OLTSS. The Waiver Advisory Committee is comprised of provider representatives, including, but not necessarily limited to the Maryland Association for Adult Day Services (MAADS), Health Facilities Association of Maryland (HFAM), LifeSpan, participants and family members. The Waiver Advisory Committee meets quarterly to review proposed regulations, policy changes, waiver amendments and renewals, and make recommendations. Regular updates on proposed regulatory changes, amendments, renewals, etc. regarding the Medical Day Care Services Waiver are provided by MDH OLTSS staff.

When new or amended regulation, a waiver amendment or renewal is proposed by the OLTSS, a notice is required to be published for public comment. Request for public input for the waiver amendment was posted in the Maryland Register, Issue date August 22, 2025, which is available electronically and in hardcopy. An electronic version of the amendment application was posted to the Department's website on August 22, 2025. Flyers are posted in the MDH at 201 W. Preston St. and distributed to Medical Day Care centers via MAADS describing how to access electronic and hardcopies, and how to provide comments. The public comment period ran from August 22, 2025, through September 22, 2025. The Department received XXXXXXXX.

Maryland's Tribal Government, the Urban Indian Organization (UIO), was consulted and provided notice and copies of the redline and clean waiver application via email on August 22, 2025. The UIO responded via email on XXXXXXXX stating XXXXXXXX.

The copy of the flyer is below:

MARYLAND DEPARTMENT OF HEALTH

Medical Day Care Services Waiver — 1915(c) MEDICAL DAY CARE SERVICES WAIVER AMENDMENT & 1915(b)(4) INITIAL MDC CASE MANAGEMENT AWARD APPLICATION

Request for Public Comment

The Maryland Department of Health (MDH) will submit a 1915(c) Medical Day Care Services Waiver amendment application for the Medical Day Care Services Waiver (MDC Waiver) to the Centers for Medicare and Medicaid Services (CMS) to amend MDC Waiver effective February 1, 2026. The MDH proposes that the MDC waiver aligns the number of unduplicated participants being served with the current trends and provides case management services to medical day care participants to support program participants and enable them to remain in their homes and communities.

The Maryland Department of Health (MDH) will submit a 1915(b)(4) Medical Day Care Services Waiver application for the Medical Day Care Services Waiver (MDC Waiver) to the Centers for Medicare and Medicaid Services (CMS) to initiate an MDC Waiver effective February 1, 2026. The MDH proposes that CMS provide authority to award interested vendors a contract to provide case management services to medical day care participants.

The Notice of Request for Public Comments have been posted in the Maryland Registrar issued on August 22 and is available in public libraries throughout the state. In addition, it has been posted at the main offices of the Maryland Association of Medical Adult Day Services (MD-MADS) and participating Medical Adult Day Care agencies. Hard

[copies of the proposed updates are available for public review at these Adult Day Care locations. To request printed copies, please contact David Cline at \(240\) 761-1344 or email \[mdh.mdcpubliccomments@maryland.gov\]\(mailto:mdh.mdcpubliccomments@maryland.gov\).](#)

[A copies of the MDC Waivers will be available on the MDH site at:  
<https://health.maryland.gov/mmcp/waiverprograms/Pages/Home.aspx>](#)

[Public comments can be emailed to \[mdh.mdcpubliccomments@maryland.gov\]\(mailto:mdh.mdcpubliccomments@maryland.gov\) or mailed to MDC Public Comments, Office of Long Term Services and Supports, Maryland Department of Health, 201 W. Preston St, Office 129, Baltimore, MD 21201. Public comments will be accepted from August 22, 2025, through September 22, 2025.](#)

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

## 7. Contact Person(s)

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**A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:****Last Name:**

Smith

**First Name:**

Jamie

**Title:**

Director, Office of Long Term Services and Supports

**Agency:**

Maryland Department of Health

**Address:**

201 W. Preston St., 1st floor

**Address 2:****City:**

Baltimore

**State:**

Maryland

**Zip:**

21201

**Phone:**

(410) 767-1431

Ext:



TTY

**Fax:**

(410) 333-5362

**E-mail:**

Jamie.smith1@maryland.gov

**B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:****Last Name:****First Name:****Title:****Agency:****Address:****Address 2:****City:****State:**

Maryland

Zip:

Phone:

Ext:

☐

TTY

Fax:

E-mail:

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:



Phone:

(410) 767-1431

Ext:

☐

TTY

Fax:

(410) 333-5362

E-mail:

**Attachments**

Jamie.Smith1@maryland.gov

**Attachment #1: Transition Plan**

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

- ☐ Replacing an approved waiver with this waiver. Combining waivers.
- ☐ Splitting one waiver into two waivers. Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☒ Reducing the unduplicated count of participants (Factor C). ☐
- ☒ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

The unduplicated count and number of participants served at any point in time are currently over projected resulting in areas of improvement in utilization and expenditure projection, monitoring and reporting. The program aims to align with the current and trending enrollment figures.

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable.

### Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

☒ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

☒ **The Medical Assistance Unit.**

Specify the unit name:

Maryland Department of Health, Office of Long Term Services and Supports – Division of Community Long Term Care

(Do not complete item A-2)

☐ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

☐ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

### Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the

umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Office of Long Term Services and Supports (OLTSS) contracts with a Utilization Control Agent (UCA) to determine the level of care (LOC).

~~The UCA evaluates all participants who are dually enrolled in the Community First Choice program, annually, to determine continuity of meeting the medical eligibility requirement, a nursing facility level of care, by assessing each participant using the chosen assessment tool of the Department.~~

The UCA evaluates all pending nursing facility LOC assessments conducted by the local health department on initial applicants to determine if an applicant meets the nursing facility LOC. When the clinical information is insufficient to meet the criteria for nursing facility LOC, supporting medical documentation is requested and uploaded to the LTSSMaryland data management system, for review by the UCA. In some instances, a face-to-face assessment by a nurse and/or a physician, may be required to determine nursing facility LOC eligibility or ineligibility.

Maryland's standardized assessment along with the algorithm for LOC determination are programmed into the LTSSMaryland data management system. The algorithm calculates whether an individual meets the institutional LOC based on the assessment data. Maryland's UCA verifies 5% of the approval determinations made via the algorithm to verify the accuracy of the algorithm. The UCA also reviews 100% of the assessments that are not approved through the algorithm that become pending and determines the LOC via document review. A second review is conducted by the UCA physician prior to the issuance of denial when a determination is made by the UCA nurse to deny LOC.

☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver

operational and administrative functions and, if so, specify the type of entity (*Select One*):

☐ Not applicable

☒ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- ☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

-The local health department (LHD) evaluates dually enrolled participants annually to determine continuity of meeting the medical eligibility requirement, a nursing facility level of care, by assessing each participant using the chosen assessment tool of the Department.

The Assessment Evaluation and Review Services (AERS) is a statewide mandated program located within each local health department in Maryland. AERS staff, comprised of nurses and social workers, conduct comprehensive social and medical evaluations of waiver applicants, with support from the contracted utilization control agent.

~~The Office of Long Term Services and Supports (OLTSS) contracts with a Utilization Control Agent (UCA) to determine the level of care (LOC).~~

~~The UCA evaluates all participants annually to determine continuity of meeting the medical eligibility requirement, a nursing facility level of care, by assessing each participant using the chosen assessment tool of the Department.~~

The UCA evaluates all pending nursing facility LOC assessments conducted by the local health department on initial applicants to determine if an applicant meets the nursing facility LOC. When the clinical information is insufficient to meet the criteria for nursing facility LOC, supporting medical documentation is requested and uploaded to the LTSSMaryland, for review by the UCA. In some instances, a face-to-face assessment by a nurse and/or a physician, may be required to determine nursing facility LOC eligibility or ineligibility.

In alignment with the case management implementation timeline, the OLTSS will be responsible for providing a choice of CMA to enrolled participants of the waiver.

## Appendix A: Waiver Administration and Operation

**5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of Long term Services and Supports (OLTSS) contracts with a utilization control agency (UCA) ~~to assess for continued level of care and to~~ review nursing facility LOC assessments that do not meet the interRAI algorithm. Administrative staff for the MDH OLTSS Administration, monitors the UCA contract for the timeliness of determinations on pending nursing facility LOC decisions and medical staff monitors the appropriateness of decisions.

The OLTSS contracts with the case management agencies (CMA) chosen to provide case management services. The CMAs will be monitored by the Division of Community Long Term Care staff for compliance with the contract.

## **Appendix A: Waiver Administration and Operation**

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**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The SMA uses a number of methods to assess the performance of the UCA contracted to conduct level of care (LOC) determinations.

The UCA sends monthly statistical reports to the SMA, which are used for the ongoing review of the UCA for timeliness and appropriateness of LOC determinations. There are regularly scheduled conference calls (at least monthly) with the UCA to discuss operational issues. The SMA clinical staff, consisting of physicians and nurses, are available on an ongoing basis to consult with the UCA as needed for policy clarification as well as individual case consultations. Additionally, the SMA clinical staff review all LOC determinations that result in appeals by participants.

If the SMA review indicates ongoing, systematic problems in LOC decision-making, the SMA will pursue a series of corrective actions, including designating clinical staff to review cases in dispute and identify areas where training may be required, and conducting training for the UCA as indicated. The SMA will increase its level of involvement in the decision-making process before issuing LOC determination notices to applicants and participants if training and technical assistance fail to improve the UCA's performance. If these efforts fail to improve performance, the SMA will pursue financial sanctions against the UCA and ultimately, as a last resort, terminate the UCA's contract.

Nursing facility LOC assessments are conducted using the interRAI Home Care assessment. Initial nursing facility LOC assessments are conducted by the Local Health Departments (LHD). Annual nursing facility LOC assessments are conducted by adult medical day care provider~~the utilization control agent (Telligen)~~.

When an interRAI assessment is conducted, a decision of approved or pending is determined by way of the interRAI algorithm. The UCA reviews a sample of the approvals to ensure the appropriateness of the decision made. When a nursing facility LOC assessment requires review, it is pended. The UCA is responsible for determining medical eligibility for pending nursing facility LOC decisions. MDH LTSS staff monitors initial and annual nursing facility LOC assessments and determinations through the LTSSMaryland system.

The UCA contract monitor shares monthly reports to the OLTSS Staff, capturing the number of applications, timeliness and duration of the review. The UCA contract monitor implements investigations and actions as necessary.

The OLTSS, will require that all activities completed by the case management agencies are entered into the LTSSMaryland data management System. The SMA monitors all case management agencies through reports built into the system, and as the need arises, custom reporting. This includes an evaluation of all functions, including developing and submitting plans of service (POS), submitting reportable events (RE) and the associated intervention and action plans, and submitting activities for reimbursement in line with the solicitation. Identified deficiencies require that the case management agency submit an acceptable corrective action plan (CAP) to the SMA. The case management agency receives a letter indicating when the review has been successfully closed and the CAP has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the required functions of the case management agency.

## Appendix A: Waiver Administration and Operation

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*



Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care waiver eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

#### i. Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*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:

**AA PM1: % of nursing facility LOC decisions completed timely by the UCA in accordance with the Medicaid contract; Numerator: # of decisions made within the required timeframe; Denominator: # of**

nursing facility LOC decisions made by the UCA

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input checked="" type="checkbox"/> Other Specify: <div>semi-annually</div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="semi-annually"/>

**Performance Measure:**

AA PM2: ~~PM2~~ # & % of case management agency reviews completed by the State or its designee per waiver year. N: Number of case management agency reviews completed per waiver year. D: Number of case management agency reviews completed by the State or its designee per waiver year.

**Data Source (Select one):** Provider performance monitoring If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> <b>Other</b> Specify:	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 200px; height: 30px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 200px; height: 30px; margin-top: 5px;"></div>

- 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

PM1: MDH OLTSS staff monitor and review nursing facility LOC assessments and decisions through LTSS Maryland. If an MDH monitoring and review indicates ongoing, systematic problems in nursing facility LOC assessments and decision-making, a series of corrective actions including designating clinical staff to review cases in dispute and identify areas where training may be required, and conducting training for AERS, medical day care providers, or the UCA, as indicated. Medicaid will increase the level of Departmental involvement in the decision-making process before issuing nursing facility LOC determination notices to recipients if training and technical assistance fail to improve performance. If these efforts fail to improve performance, the Department has the option of pursuing financial sanctions against medical day care providers or the UCA. As a last resort, the UCA contract may be terminated, and medical day care providers may be disenrolled from the program.

Nursing facility LOC assessments are conducted using the interRAI Home Care assessment. Initial nursing facility LOC assessments are conducted by the Local Health Departments (LHD). Annual nursing facility LOC assessments are conducted by the adult medical day care provider~~utilization control agent (Telligen)~~.

When an interRAI assessment is conducted, a decision of approved or pending is determined by way of the interRAI algorithm. The UCA reviews a sample of the approvals to ensure the appropriateness of the decision made. When a nursing facility LOC assessment requires review, it is pended. The UCA is responsible for determining medical eligibility for

pending nursing facility LOC decisions. MDH LTSS staff monitors initial and annual nursing facility LOC assessments and determinations through the LTSSMaryland system.

The UCA contract monitor shares monthly reports to the OLTSS Staff, capturing the number of applications, timeliness and duration of the review. The UCA contract monitor implements investigations and actions as necessary.

PM2: In alignment with the case management implementation timeline, the OLTSS, will require that all activities completed by the case management agencies are entered into the LTSSMaryland data management system. The SMA monitors all case management agencies through reports built into the system, and as the need arises, custom reporting. This includes an evaluation of all functions, including developing and submitting plans of service (POS), submitting reportable events (RE) and the associated intervention and action plans, and submitting activities for reimbursement in line with the solicitation. Identified deficiencies require that the case management agency submit an acceptable corrective action plan (CAP) to the SMA. The case management agency receives a letter indicating when the review has been successfully closed and the CAP has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the required functions of the case management agency.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

## 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 Administrative Authority that are currently non-operational.

☒ No ☐ Yes

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

## 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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	16	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	16	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The individual may not be enrolled in another Medicaid 1915(c) waiver or Program of All-Inclusive Care for the Elderly (PACE).

**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:*

Disabled individuals enrolled in the waiver by age 64 can stay in the waiver as long as they continue to meet all eligibility criteria.

## Appendix B: Participant Access and Eligibility B-2: Individual Cost Limit (1 of 2)

**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:*

- ☐ **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:

Specify:

## Appendix B: Participant Access and Eligibility B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- 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:

- 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:

## 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	

Waiver Year	Unduplicated Number of Participants
	7720
Year 2	7913
Year 3	8111
Year 4	<del>5483</del> 8314
Year 5	<del>5633</del> 8521

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

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	6547
Year 2	6710
Year 3	6879
Year 4	<del>5483</del> 7051
Year 5	<del>5633</del> 7227

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**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).

## Appendix B: Participant Access and Eligibility

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

**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 Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in**

the waiver.

**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 who are 16 years and older, eligible for traditional Medicaid State Plan services, and meet nursing facility level of care who do not participate in another HCBS waiver or PACE will be eligible for the MDC Services Waiver. Eligible individuals are enrolled in the waiver program on a first-come, first-served basis until the annual cap on the unduplicated number of participants (see table B-3-a) or the maximum number of participants (see table B-3-b) on waiver participation is reached. When the waiver reaches its full capacity, MDH will establish a statewide registry. When waiver slots become available, due to attrition or an increase in the annual cap of enrollees, applicants will be notified on a first come, first serve basis.

The statewide registry will identify the date and time the individual indicated interest in applying to the Waiver. The individuals that indicated an interest in the Waiver will be evaluated for medical, technical and financial eligibility when their name comes to the top of the registry. The applicant is offered a waiver slot if, eligible, and their health and safety needs can be met through waiver services. Individuals that do not meet eligibility requirements to participate are offered appeal rights.

## Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

**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**
- ☐ **Low income families with children as provided in §1931 of the Act 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:*



1902(a)(10)(A)(i)(I), §1925 — TMA

~~42 CFR 435.110 — Parent/ caretaker relative~~

42 CFR 435.145 — IV-E foster care and adoption assistance recipients

~~42 CFR 435.116 — Pregnant women~~

~~42 CFR 435.118 — 6-19 year old poverty level children (MDC participants 16-19 years old)~~

~~1902(a)(10)(A)(i)(VIII)~~ 42 CFR 435.119 — New adult

~~1902(a)(10)(A)(i)(IX)~~ 42 CFR 435.150 — Former

foster care child 42 CFR 435.227 — State adoption

assistance

42 CFR 435.229 — Optional targeted low income children (Medicaid expansion CHIP)

42 CFR 435.222 - Optional eligibility for reasonable classification of individuals under age 21

*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 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:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*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:

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

## B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

### b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

### 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).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

### 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 submit Appendix B-5 and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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## B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

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

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. 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).

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

## 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 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:

**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:*

**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 under contract with the Medicaid agency.**

*Specify the entity:*

☒ **Other**

*Specify:*

The Office of Long Term Services and Supports (OLTSS) contracts with a Utilization Control Agent (UCA) and the State utilizes the local health department's Assessment Evaluation and Review Service (AERS). Level of care (LOC) assessments are conducted using the interRAI tool. The AERS program is comprised of trained registered nurses and licensed social workers responsible for conducting initial and annual LOC assessments for applicants and participants. The UCA is comprised of registered nurses responsible for conducting and determining medical eligibility when a level of care decision is not determined by way of the interRAI algorithm.

**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:

**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.

The initial level of care (LOC) evaluations are performed by a licensed registered nurse, or a licensed social worker. If the algorithm of the tool used, does not return an approval, a physician will review.

For applicants in the community, the local health Department's Adult Evaluation and Review Service (AERS) will conduct the initial LOC evaluation using the interRAI tool. That evaluation will be performed by a registered nurse or social worker. The local health departments may be supported by the UCA as necessary, and determined by the UCA contract monitor in conjunction with the UCA, when requests for assistance are presented to the UCA contract monitor. The UCA assists the AERS by conducting initial LOC assessments when there has been a request by the AERS.

For applicants in a long term care facility or hospital, the social worker will conduct the initial LOC evaluation using the 3871B MDH form. That evaluation will be forwarded as a referral to the utilization control agent (UCA) for a determination of level of care.

The State Medicaid Agency contracts with a UCA that is a Quality Improvement Organization. The UCA employs licensed registered nurses and physicians to certify the nursing facility LOC. The Office of Long Term Services and Support also employs a physician, who will assist in the determination of LOC when there are unusually complex or contested decisions. LOC determinations may be subject to review and approval by the Medicaid agency.

**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.

The interRAI is the current tool used to assess level of care for waiver applicants and Medicaid participants. The interRAI-HC tool was implemented with CMS approval and covers five core domains including Activities of Daily Living, Instrumental Activities of Daily Living, Medical Conditions/Diagnoses, Cognitive Function and Memory/Learning, and Behavior Concerns. The assessment was developed in 1994 based on CMS' Minimum Data Set (MDS) 2.0, is used worldwide and has shown to have robust inter-rater reliability. For more information and publications related to its testing and use, please see their website at <http://interrai.org/home-care.html>.

The interRAI is an assessment and planning tool. The interRAI identifies the State's nursing facility level of care requirements as well as helps identify strengths and weaknesses that are used in planning for services. The strengths, weaknesses are used to develop a plan of care and a recommendation for services. The 3871B is an assessment tool which focuses on the State's nursing facility level of care requirements.

The interRAI differs in its evaluation of nursing facility level of care by asking additional questions related to the participant's formal and informal supports in order to develop a more refined plan of care. It assists participants, families and providers with identifying services, risks and other health-related issues.

Assessments are completed by trained nursing and social work staff at each local health department in the State of Maryland as well as by enrolled Medicaid providers. Each staff person receives a two-day in-person interRAI training which is also supported through an online training tool for ongoing use. Handbooks are also available to use as a guide when completing the interRAI.

Based on the uniform training and consistent questions used to determine nursing facility level of care, the assessment process is reliable independent of who completes the assessment or if the participant is re-assessed. After the assessment is completed, the core criteria determining nursing facility level of care is reviewed through an algorithm and/or review staff. The criteria used to determine level of care is the same.

The purpose of the interRAI is to document criteria needed to meet nursing facility level of care and to assist participants, families and case managers/supports planners in developing a plan of care. The interRAI asks specific questions related to both purposes. Specifically, the outcome of nursing facility level of care is measured by examining answers to criteria consistent with State regulations and transmittals defining nursing facility level of care. The results of each assessment can be cross-walked with State criteria to determine whether nursing facility level of care is met.

The interRAI's other purpose is to assist the participant, family and case manager/supports planner in developing a plan of care. Based on answers to formal and informal supports and health-related responses, the interRAI identifies Clinical Assessment Protocols (CAPs). These CAPs are used in the planning for services and reduce risks related to re-institutionalization.

Both the interRAI and the 3871B instruments include specific questions directly corresponding to requirements for level of care listed within these transmittals. The core criteria determining nursing facility level of care is consistent between both tools. Based on the answers provided to these questions, a level of care is determined. The criteria in Nursing Home Transmittals 213, 217 and 237 includes questions related to the following:

- Skilled Nursing and Rehabilitation including suctioning, IV therapy, skin condition, feeding tube, ventilator, extensive physical therapy;
- Health Related Services including Activity of Daily Living Needs (bathing, dressing, toileting, eating and mobility), and Instrumental Activities of Daily Living (phone use, money management, housekeeping, and medication management);
- Cognition including the Brief Interview for Mental Status (BIMS); and
- Behavior including wandering, hallucinations, aggressive behavior, disruptive and self-injurious behavior.

Both assessments have been cross-walked with the transmittals to ensure that all criteria are covered during the assessment to make an informed decision on nursing facility level of care. This consistency ensures that regardless of which tool is used, the resulting decision is the same.

**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:

Initial nursing facility LOC assessments are conducted by Assessment Evaluation and Review Services (AERS); the UCA may be called upon to assist with the volume of initials as necessary to assure timely LOC assessments. Registered nurses and/or social workers employed by AERS conduct nursing facility LOC assessments of applicants and participants, using the interRAI. Annual nursing facility LOC assessments for participants enrolled in the MDCSW are conducted by registered nurses employed by medical day care providers or registered nurses or social workers employed by AERS. ~~Annual nursing facility LOC assessments for participants enrolled in the MDCSW are conducted by the UCA.~~

When an interRAI assessment is conducted, a decision of approved or pended by way of the interRAI algorithm. The UCA reviews a sample of the approvals to ensure the appropriateness of the decision made. When a nursing facility LOC assessment requires review, it is pended. The UCA is responsible for determining medical eligibility for all pending level of care decisions. MDH OLTSS staff monitors the processing of initial and annual nursing facility LOC assessments and determinations through the LTSSMaryland system.

The UCA evaluates all pending nursing facility LOC assessments to determine if an applicant meets the nursing facility LOC. When the clinical information is insufficient to meet the criteria for nursing facility LOC, supporting medical documentation is requested and uploaded to the LTSSMaryland, for review by the UCA. In some instances, a face-to-face assessment by a nurse and/or a physician, may be required to determine nursing facility LOC eligibility or ineligibility.

- 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*):

The UCA/LHD ~~are~~ is responsible for the timely submission of annual nursing facility LOC assessments for dually enrolled participants. AMDC are responsible for annual LOC assessments when the participant is not dually enrolled. The dates for future annual nursing facility LOC assessments are maintained in the LTSSMaryland system. LTSSMaryland alerts the UCA-LHD 60 days prior to the annual LOC due date. MDH OLTSS staff monitor and track the timely submission of nursing facility LOC assessments through the 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:



The interRAI and nursing facility LOC determinations are maintained in the LTSS Maryland. Maryland Medicaid regulations, which govern all Medicaid providers, require that providers must maintain adequate records for a minimum of six (6) years, and make them available, upon request, to the SMA. The Utilization Control Agent (UCA) is also contractually required to maintain records for a minimum of six (6) years.

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

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:

**LOC PM1: % of new applicants receiving a nursing facility LOC determination prior to receiving services; Numerator # of new applicants receiving a nursing facility LOC approval; Denominator: # of enrolled initial applicants**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**UCA report**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence

		Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:****LOC PM2: % of individuals with a reasonable indication of service need who receive**

level of care evaluation; Numerator: # of individuals with a reasonable indications of service need who receives level of care evaluation; Denominator: # of individuals determined to need a level of care evaluation.

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="checked" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
--	---------------------------------

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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.*

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine 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 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:**

**LOC PM3: % of participants nursing facility LOC decisions approved according to nursing facility LOC criteria in LTSSMaryland; Numerator: # of validated nursing facility LOC decisions; Denominator: # of audited nursing facility LOC decisions**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <div>random 5% sample</div>
	<input checked="" type="checkbox"/> Other Specify: <div>semi-annually</div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="semi-annually"/>

**Performance Measure:**

**LOC PM4: % of the random sample of approved NF level of care determinations where the algorithm was applied appropriately. Numerator: # of approved NF level of care determinations reviewed where the algorithm was applied appropriately Denominator: # of approved NF level of care determinations reviewed**

**Data Source (Select one):**

**Record reviews, Other on-site**

If 'Other' is selected, specify: The Department will determine if the record review requires on-site or off-site review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>



	<input checked="checked" type="checkbox"/> <b>Continuousl y and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify :
--	---	---

	<input type="checkbox"/> Other Specify:  	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:  	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:  

**Performance Measure:**

**LOC PM5: % of denied NF level of care determinations reviewed for accuracy**  
**Numerator: # of denied NF level of care determinations reviewed**  
**Denominator: # of denied NF level of care determinations**

**Data Source (Select one):**

Record reviews, ~~on-site~~ **Other**

If 'Other' is selected, specify: The Department will determine if the record review requires on-site or off-site review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Agency		
--	--	--

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>5% random sample of NF level of care approvals</div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The SMA will contact the case management agency if level of care (LOC) determination or redetermination delays are identified. The agencies are required to act proactively to ensure that LOC assessments and waiver enrollments are processed within the timeline required by federal regulations and that the redetermination process is completed before the LOC expires.

If the initial LOC assessment results in an approval, the applicant will work with their case management agency toward enrollment into the waiver. If the applicant is not approved, the applicant will be notified in writing by the OLTSS that he/ she is not eligible for the MDCSW and informed of his/ her right to appeal the decision to an Administrative Law Judge.

The UCA/LHD is responsible for the timely submission of annual nursing facility LOC assessments if the participant is dually enrolled and the AMDC is responsible for annual LOC assessments if the participant is not dually enrolled. If approved, the participant will continue to receive the medical day care service. When a participant is denied a nursing facility LOC, the MMIS does not allow centers to be paid for dates of service for which the participant does not have a nursing facility LOC. Participants are notified, in writing, by the OLTSS that they are not eligible for the MDCSW and informed of their right to appeal the adverse decision to an Administrative Law Judge and may be assisted by their case management agency to file the appeal timely and appropriately.

The UCA validates a percentage of nursing facility LOC approvals. If during the validation review it is determined that a nursing facility LOC determination was incorrect, the applicant or participant continues to receive services pending the outcome of a new evaluation. The OLTSS is consulted and an investigation is initiated to determine why the nursing facility LOC was incorrect. When appropriate, a corrective action plan is implemented.

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify: <div data-bbox="320 210 798 291" style="border: 1px solid black; height: 36px; width: 299px; margin-top: 10px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**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 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).

When an individual applies for the waiver, a case manager will make an initial visit to discuss services and supports available through the waiver and other available services. The individual and his or her representative are informed of the right to choose between institutional and community-based services and also the right to choose among all enrolled waiver providers.

The Freedom of Choice (FOC) Form documents the choices and must be signed by the individual or his or her representative in order to complete the waiver application process. A witness is required to also sign the FOC form.

A Freedom of Choice form is completed and signed by all waiver applicants and participants initially and annually. The applicant will not be enrolled in the waiver program until the form is signed and uploaded to the LTSSMaryland system for review and verification by OLTSS staff. The form is used to confirm an applicant's or participant's:

- Choice to receive home and community-based services through the MDC Service Waiver, or institutional long term care services in a nursing facility;
- Receipt of a list of eligible providers; and
- Choice of a specific provider(s).

**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.



Signed Freedom of Choice forms are maintained in the LTSS Maryland. The Freedom of Choice Form is maintained in the participant's file at the case management agency, which provides services to the participant. Forms are maintained for a minimum of six (6) years. The participant's choice is also recorded and maintained in the data management system.

## 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 clients, and translation of forms and documents. Additionally, interpreter resources are available for individuals who contact OLTSS for information, requests for assistance or complaints.

The OLTSS website contains useful information on Medicaid waivers and other programs and resources. The State also provides translation services at fair hearings if necessary. If a LEP 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 he/ she is able to sufficiently understand the proceedings. If the appellant is unable to sufficiently understand the proceedings, the hearing will be postponed, and an interpreter will be secured for a future hearing.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Medical Day Care		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Medical Day Care

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

#### Service Definition (Scope):

Medical Day Care is a program of medically supervised, health-related services provided in a non-institutional, community-based setting to medically handicapped individuals who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living. Medical day care centers must be open to participants at least 6 hours a day, 5 days a week, and up to two meals are required to be provided. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Participants are expected to attend at least one day a week as identified within their person-centered plan of service. The provider is reimbursed for service rendered when the participant attends the center four or more hours.

The State requires four or more hours to ensure the participant's assessed (i.e. medical, therapeutic, cognitive and activity of daily living) needs are adequately met. The medical day care service is a bundled service related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition. It is a day of care, not an hourly service. Primarily, the physician or the nurse practitioner prescribes the frequency of attendance in terms of a day of care that may include the scope of the services needed. The frequency of attendance is a discussion that occurs between the physician or the nurse practitioner and the participant prior to the order being written. The medical order is a component of the plan of care. The case manager-developed plan of care is a written plan established in accordance with a signed medical order and an assessment of the participant's health status. The plan must be signed by the participant or their authorized representative to ensure their participation in the process and that their preferences are being met.

Medical Day Care includes the following services:

- (1) Health care services supervised by the director, medical director, or health director, which emphasize primary prevention, early diagnosis and treatment, rehabilitation and continuity of care;
- (2) Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;
- (3) Physical therapy services, performed by or under supervision of a licensed physical therapist;
- (4) Occupational therapy services, performed by an occupational therapist;
- (5) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene;
- (6) Nutrition services;
- (7) Social work services performed by a licensed, certified social worker or licensed social work associate;
- (8) Activity Programs; and
- (9) Transportation Services.

#### **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A waiver participant must attend the MDC a minimum of 4 hours per day for the service to be reimbursed. The frequency of attendance is determined by the physician orders and is part of the service plan. Medical Day Care services are limited to additional services not otherwise covered under the state plan, including EPSDT, but are consistent with the waiver's objectives of avoiding institutionalization.

The Program will reimburse for a day of care when this care is:

- (1) Medically necessary;

Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;

Provided to participants certified by the Department as requiring nursing facility care under the Program. The services provided by an MDC, in the community, must mimic the nursing facility services provided in an institution. Nursing facility services provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services or, on a regular basis, health-related care and services which can be made available to them only through institutional facilities.;

Provided to participants certified present at the medical day care center a minimum of 4 hours a day by an adequately maintained and documented participant register;

Specified in the participant's service plan; and

Limited to one unit per day.

**Service Delivery Method** (check each that applies):

☐ Participant-directed as specified in Appendix E Provider managed

☒ Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person Relative

☐ Legal Guardian Provider Specifications:

☐

Provider Category	Provider Type Title
Agency	Medical Day Care Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service Service Name: Medical Day Care**

**Provider Category:**

Agency

**Provider Type:**

Medical Day Care Provider

**Provider Qualifications License** (specify):

Office of Health Care Quality - Verifies all providers of this waiver have a license and/or certification to operate. Medical day care providers are required to possess a facility license granted by the OHCQ in order to operate an adult medical day care facility prior to being enrolled as a Medicaid provider.

**Certificate** (specify):

**Other Standard** (specify):

Meet the requirements of COMAR 10.09.07, which requires that Medical Day Care providers:

- Be licensed under the COMAR 10.12.04 Day Care for the Elderly and Adults with a Medical Disability;
- Meet the requirements of COMAR 10.09.36;
- Be open to participants at least 6 hours a day, 5 days a week, and post hours of operation;
- Verify the licenses and credentials for all professionals employed by or contracting with the medical day care center;
- Provide or arrange for the provision of any covered service required by a plan of care;
- Demonstrate to the satisfaction of the Program that a need exists for medical day care in the service area and that the provider has the necessary expertise to deliver the service;
- Have policies and procedures as required under COMAR 10.12.04;

Maintain medical records  
 Have an emergency plan for each participant;  
 Provide emergency procedures training for medical day care staff;  
 Have accurate daily attendance records;  
 Have accurate daily transportation records;  
 Establish a multidisciplinary team;  
 Have a quality assurance program; and  
 Have a signed and dated corrective action plan transferring the participant to the appropriate service, if it is determined that the medical day care center's program is not appropriate for an individual participant.

**Verification of Provider Qualifications Entity Responsible for Verification:**

Office of Health Care Quality - Verifies all providers of this waiver have a license and/or certification to operate. Medical day care providers are required to possess a facility license granted by the OHCQ in order to operate an adult medical day care facility prior to being enrolled as a Medicaid provider.

The Office of Long Term Services verifies the provider is in compliance with OHCQ licensing upon enrollment.

**Frequency of Verification:**

The OHCQ verifies every two years that providers have remained in compliance with licensing regulations.

Every five years after enrollment as a Medicaid provider, providers are revalidated by the Department of Health's Provider Enrollment and Compliance Team.

Service Type:

Statutory Service  
Service:

Case Management  
Alternate Service Title (if any):  
Medical Day Care Case Management  
HCBS Taxonomy:  
Category 1:

01 Case Management  
Sub-Category 1:

01010 case management  
Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :  
Service is included in approved waiver. There is no change in service specifications.  
Service is included in approved waiver. The service specifications have been modified.  
Service is not included in the approved waiver.

**Service Definition (Scope): Character Count: 3361 out of 12000**

Medical Day Care is a program of medically supervised, health-related services provided in a non-institutional, community-based setting to medically handicapped individuals who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living. Medical day care centers must be open to participants at least 6 hours a day, 5 days a week, and up to two meals are required to be provided. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Participants are expected to attend at least one day a week as identified within their person-centered plan of service. The provider is reimbursed for service rendered when the participant attends the center four or more hours.

The State requires four or more hours to ensure the participant's assessed (i.e. medical, therapeutic, cognitive and activity of daily living) needs are adequately met. The medical day care service is a bundled service related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition. It is a day of care, not an hourly service. Primarily, the physician or the nurse practitioner prescribes the frequency of attendance in terms of a day of care that may include the scope of the services needed. The frequency of attendance is a discussion that occurs between the physician or the nurse practitioner and the participant prior to the order being written. The medical order is a component of the plan of care. The case manager-developed plan of care is a written plan established in accordance with a signed medical order and an assessment of the participant's health status. The plan must be signed by the participant or their authorized representative to ensure their participation in the process and that their preferences are being met.

Case management includes all administrative activities to assist applicants and participants with eligibility, care coordination, POS development, and service maintenance and monitoring. CMAs selected through this solicitation will provide case management services to MDCSW applicants and participants in accordance with the solicitation's requirements.

Case managers from the CMAs assist with accessing and maintaining Medicaid coverage while coordinating community services and support from various providers and funding sources to develop a comprehensive POS for successful community living. Moreover, they conduct quality assurance and improvement activities to ensure services are delivered as outlined in the POS and the services meet or exceed established standards. CMAs must have a physical office in Maryland, centrally located in the counties(s) served, with coverage during normal business hours, five (5) days a week, and supply a toll-free number for after-hours and emergency access.

Ongoing case management responsibilities include monitoring POS implementation, the participant's health, safety, and welfare in the community, maintaining an active medical order prescribing medical day care services at least every 180 days, the quality of delivered services and supports, and ensuring compliance with the OLTSS' RE Policy. The CMA will also review all available resources to ensure the provided services are consistent with the POS.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:****Character Count: 1206 out of 6000**

The CMA shall bill the Department for all applicable services rendered. The CMA shall not bill for the following as they are not covered services. These include, but are not limited to:

Those that are less than eight (8) minutes in duration (See Appendix 1 for examples).

Routine eligibility verification.

Time spent engaged in activities required by a credentialing, certification, or oversight entity such as gathering and submitting care plans, service data, or other information.

Contact with the Department or its designee to request or review authorization of services.

Completion of activities for the purpose of payment and any associated documentation, as well as completing progress notes and required forms.

Individual or group supervision, routine case reviews, and ad hoc consultation, including for the purpose of treatment planning, unless the participant is present.

Time spent in staff training.

Travel time.

Attempted contacts or leaving messages, including but not limited to missed or canceled appointments and

visits to the participant when the participant is not present, and

Services provided by staff who do not meet the definition of and minimum qualifications for a case manager.

**Service Delivery Method (check each that applies):**

Participant-directed as specified in Appendix

X Provider managed

X Remote/via Telehealth

**Specify whether the service may be provided by (check each that applies):**

Legally Responsible Person

Relative

Legal Guardian

**Provider Specifications:**

**Provider Category**

Agency

**Provider Type**

Case Management Agency

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Case managers are required to meet the following minimum qualifications:

At least two (2) years of experience providing community-based case management services and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities beyond those ancillary to the provision of other services.

Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional and national entities.

At least two (2) years of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs).

At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs.

Freedom from any conflicts of interest as defined in this Solicitation.

Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

**Highly Desirable Qualifications**

Experience with the PCP process and/or case management in the context of programs which operate under a philosophy of person-centeredness.

Competence in communicating with individuals in alternate formats; for example, written materials in large print, digital communication, infographics and/or the use of assistive technology, including TeleTypewriter (TTY)/Telecommunications Relay Services (TRS) and qualified sign language

interpreters.

Coordination with other organizations and/or programs that serve individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities in community-based settings.

Knowledge of other programs that serve individuals with intellectual and/or developmental disabilities, traumatic brain injury or behavioral health conditions, including mental illness and substance use disorders.

Competence in working with culturally, racially, ethnically and religiously diverse populations.

Competence in working with low-income populations, including individuals experiencing homelessness.

The providers that are identified through the solicitation process provide their staff with training on the following topics:

Applicable regulations, including but not limited to: Code of Maryland Regulations (COMAR) 10.09.07, 36, and 61,

Medicaid waiver and State plan program eligibility and service offerings,

Person-centered planning (PCP), and applicant/participant empowerment,

Identifying and reporting abuse, neglect and/or exploitation, and the Reportable Events (RE) Policy,

Fair Hearing and Appeal Rights,

Applicant/Participant letters and forms,

Use of the LTSSMaryland Tracking System,

Strategies for de-escalation and appropriate crisis intervention,

All applicable federal and state regulations pertaining to privacy and confidentiality,

Community-based service delivery and harm reduction philosophy,

Guardianship and other forms of legal representation,

Medical Assistance Program, Managed Care Organizations (MCO) and waivers,

Community-based resources, including housing options, disability-specific resources, aging resources, behavioral health resources, assistive technology, medical equipment, and supplies and other local resources,

Reasonable Accommodation Policy and Procedures, and Characteristics of the target population.

### **Verification of Provider Qualifications**

#### **Entity Responsible for Verification:**

The Office of Long Term Services verifies the CMA is in compliance with OHCQ licensing upon enrollment.

#### **Frequency of Verification:**

Every five years after enrollment as a Medicaid provider, CMAs are revalidated by the Department of Health's Provider Enrollment and Compliance Team.

## **Appendix C: Participant Services**

### **C-1: Summary of Services Covered (2 of 2)**

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

☒ **As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**



- ☐ As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
- ☐ As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
- ☒ As an administrative activity. *Complete item C-1-c.*
- ☐ As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The SMA designated providers of case management identified through a competitive solicitation.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.**  
☐ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Case management services, scheduled to take effect on ~~February 16, 2026~~ July 1, 2024, require case management agencies to conduct Maryland CJIS background checks for all staff providing case management services.

Adult Medical Day Centers are required to comply with OHCQ requirements.

(a) In accordance with COMAR 10.12.04.14C(3) Before hiring, staff shall have a criminal background check as required by Health-General Article 19-1901 et seq., Annotated Code of Maryland, and may not have a criminal conviction or criminal history that indicates behavior that is potentially harmful to participants, as evidenced by criminal history records check.

OHCQ requires a criminal background check for all staff prior to hiring and retention of documentation of the results of the check in each personnel record. During the biennial review, OHCQ checks the personnel files to ensure background checks have been completed. If an employee at the AMDC center does not have a criminal background check on file (in the personnel record) then the center is cited.

The center receives a deficiency related to the criminal background check not being completed via a deficiency report completed by OHCQ. In response to the deficiency report, the center must complete a plan of correction documenting when the criminal background check will be completed and return the plan of correction to OHCQ within 10 calendar days. Once the plan of correction has been received with the date the criminal background check will be completed then OHCQ sends out a letter of approval for the plan of correction.

(b) The scope of the investigation is State of Maryland only.

(c) OLTSS verifies that provider applicants meet the waiver and regulatory requirements for provider enrollment, including OHCQ licensure and additional certification requirements. OHCQ surveys medical day care centers for compliance with Maryland licensure regulations.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☒ **No. The state does not conduct abuse registry screening.**  
☐ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

**C-2: General Service Specifications (2 of 3)**

**Note: Required information from this page is contained in response to C-5.**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- ☐ **Self-directed**
- ☐ **Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☒ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☐ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

--

**○ Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment for the MDC Services Waiver is an open process for MDC centers. Providers can apply to become MDC Services Waiver providers at any time. Providers can enroll by requesting a provider enrollment packet from MDH. The enrollment packet informs the potential applicant of the enrollment procedure. Provider qualifications are specified in Maryland regulations which are maintained on the MDH website as well as distributed by MDH LTSS staff upon request. Medical Day Care providers must be licensed by the Office of Health Care Quality (OHCQ). Once licensed by the State, the provider may apply to become a Medicaid MDC Services Waiver provider. All provider applicants who are both licensed by OHCQ and meet the Medicaid Program's condition for participation "Conditions for Participation" are enrolled and entered in MMIS. Providers are validated, and upon approval, re-enrolled every five years by the MDH provider enrollment staff.

The concurrent 1915(b) authority allows OLTSS to limit the award of case management agencies. Enrollment as a CMA may only occur after being awarded a contract through the competitive solicitation process.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory 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:**

**PM1 The % of enrolled Medicaid (MA) waiver providers required to be licensed and/or certified**

that maintain a current license and/or certification per waiver year.

N:# of enrolled MA waiver providers required to be licensed and/or certified with a current license and/or certification per waiver year.

D:# of enrolled MA waiver providers required to be licensed and/or certified per waiver

year.~~PROV PM1: % of providers that continue to meet licensing and participation standards:~~

~~Numerator: # of audited providers who meet licensing and participation standards;Denominator: # of audited providers~~

**Data Source** (Select one):

~~On-site observations, interviews, monitoring~~Record review, off-site

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> <del>Annually</del>	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly



<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**PROV PM2: PM2 – The percentage of case management agencies that meet the minimum qualifications for providing case management services per waiver year. N: Number of case management agencies that meet the minimum qualifications for providing case management services per waiver year. D: Number of case management agencies enrolled per waiver year. % of new providers that meet licensing and participation standards prior to furnishing services; Numerator: # of new providers that meet licensing and participation standards prior to furnishing services; Denominator: # of new providers**

**Data Source (Select one):**

**On-site observations, interviews, monitoring** **Record reviews, Off-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
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		<div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory 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.

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory 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:**

**PROV PM3: % of new providers completing orientation training; Numerator: # of new ~~MDC~~ providers who complete orientation training; Denominator: # of providers requesting enrollment**

**Data Source (Select one): Training verification records** If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> <del>X</del> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input checked="" type="checkbox"/> <del>Other Specify:</del> <div>semi-annually</div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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.

ii.

The MDC Provider must meet the requirements of Office of Health Care Quality (OHCQ) to become a licensed provider. Once the licensed has been issued OHCQ will conduct a quality survey very two (2) years. The validation procedure for the license shall include a reevaluation of the center by OHCQ.

OHCQ in conjunction with OLTSS conduct orientation training seminars to outline policy requirements to potential providers. OHCQ may conduct unannounced or announced licensure or complaint investigation visits as frequently as necessary to ensure compliance of the regulations or for the purpose of investigating a complaint.

The Case Management Agencies must meet requirements outlined in the invitation to bid and subsequent contract, as well as other program requirements in order to be enrolled and maintain enrollment in the MDC Waiver. The SMA verifies all providers qualifications

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

i.

When the State discovers that a provider does not meet OHCQ licensing standards, the State immediately terminates the Medicaid provider's enrollment and participants are transferred to another licensed provider.

When the State discovers that a AMDC provider or the CMA does not meet participation standards, the State immediately informs the provider and requests a corrective action plan, within 15 days, that brings the provider into compliance with qualifications. When appropriate, funds will be recovered. Follow-up occurs to ensure the corrective action plan has been implemented by the provider.

All case managers attend OLTSS' training for new case managers within 90 days of hire or at the first available training session. This training must be completed prior to the case managers rendering services. When a new CMA has not attended orientation training, the State denies the new CMA's Medicaid enrollment application.

When a new provider has not attended orientation training, the State denies the new provider's Medicaid enrollment application. Notification of the denial is forwarded to the new provider with the recommendation that they attend orientation training prior to resubmitting the Medicaid enrollment application.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**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 Qualified Providers that are currently non-operational.

☒ No ☐ Yes

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

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)



- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- ☐ **Other Type of Limit.** The state employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

Non-residential settings in this waiver are privately owned adult medical day care centers and those operated by Local Health Departments (LDH). This waiver does not authorize residential settings.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Maryland is committed to coming into full compliance with the Final Rule in advance of the deadline and the following strategies will be utilized to ensure full and ongoing compliance:

- In 2015, the MDH created Transition Advisory Teams, which met regularly through early 2017.

- The MDH reviewed Maryland law and all regulations related to the Medical Day Care Services Waiver and determined that nothing conflicted with the Final Rule; however, some areas of the Final Rule were not addressed by the regulations.

- Through the person-centered planning process, the OLTSS ensures that participants are provided the opportunity to make an informed choice regarding a setting. Medical Day Care Services Waiver participants are required to sign an FOC form prior to enrollment attesting to the choice of residence in the community (as opposed to an institution setting) and choice of setting from those who are available.

Site Visits As part of the MDH's revalidation process for all Medicaid providers, the MDH conducts site visits to ensure compliance with the standards of the ACA. In addition to these visits, the OLTSS began conducting on-site visits to medical day care sites in July 2017 to validate the results of the provider self-assessment survey and determine compliance with the Final Rule. ACA compliance is not the same as, but is in addition to site visits to validate settings compliance with the Final Rule. ACA compliance reviews did not incorporate settings criteria in their review tool. However, observations were made regarding settings criteria and issues identified were referred to the HCB settings team for further review.

**3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:**

X The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

X The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

X Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

X Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

X Facilitates individual choice regarding services and supports, and who provides them.

X Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

**Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)**

X No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (1 of 8)

### State Participant-Centered Service Plan Title:

Plan of Service (POS)

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law Licensed physician**
- ☐ **(M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).  
*Specify qualifications:*

Case management for the MDCSW, is limited to the providers identified. Case managers are required to meet the following minimum qualifications:

- At least two (2) years of experience providing community-based case management services and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities beyond those ancillary to the provision of other services.
- Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional and national entities.
- At least two (2) years of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs).
- At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs.
- Freedom from any conflicts of interest as defined in this Solicitation.
- Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

2. Highly Desirable Qualifications

- Experience with the PCP process and/or case management in the context of programs which operate under a philosophy of person-centeredness.
- Competence in communicating with individuals in alternate formats; for example, written materials in large print, digital communication, infographics and/or the use of assistive technology, including TeleTypewriter (TTY)/Telecommunications Relay Services (TRS) and qualified sign language interpreters.
- Coordination with other organizations and/or programs that serve individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities in community-based settings.
- Knowledge of other programs that serve individuals with intellectual and/or developmental disabilities, traumatic brain injury or behavioral health conditions, including mental illness and substance use disorders.
- Competence in working with culturally, racially, ethnically and religiously diverse populations.
- Competence in working with low-income populations, including individuals experiencing homelessness.

The providers that are identified through the solicitation process provide their staff with training on the following topics:

- Applicable regulations, including but not limited to: Code of Maryland Regulations (COMAR) 10.09.07, 36, and 61,
- Medicaid waiver and State plan program eligibility and service offerings,
- Person-centered planning (PCP), and applicant/participant empowerment,
- Identifying and reporting abuse, neglect and/or exploitation, and the Reportable Events (RE) Policy,
- Fair Hearing and Appeal Rights,
- Applicant/Participant letters and forms,
- Use of the LTSSMaryland Tracking System,
- Strategies for de-escalation and appropriate crisis intervention,
- All applicable federal and state regulations pertaining to privacy and confidentiality,
- Community-based service delivery and harm reduction philosophy,
- Guardianship and other forms of legal representation,
- Medical Assistance Program, Managed Care Organizations (MCO) and waivers,
- Community-based resources, including housing options, disability-specific resources, aging resources, behavioral health resources, assistive technology, medical equipment, and supplies and other local resources,
- Reasonable Accommodation Policy and Procedures, and
- Characteristics of the target population.

☒ **Social Worker**

*Specify qualifications:*

~~social worker is defined as an individual who is in compliance with the social work licensing requirements of Maryland.~~

☒ **Other**

*Specify the individuals and their qualifications:*

~~Registered Nurse as defined as an individual who is licensed in compliance with the Board of Nursing requirements of Maryland.~~

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## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (2 of 8)

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

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

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

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## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (3 of 8)

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

(a) OLTSS maintains a list of active medical day care providers to include their contact numbers and addresses. The OLTSS website offers a pamphlet containing overview information on each of its waivers and programs.

Upon entry into the waiver, and at least annually, participants are provided a list of active providers. The participant confirms receipt of the list through a signed attestation on the Freedom of Choice Consent form. Both the participant and their authorized representative may access the list at any time on the OLTSS website, or from their case manager, and hard copies are made available by MDC staff, by request.

(b) The participant and others designated by the participant are actively engaged in the person-center planning process.

Case managers are required to meet with all applicants and participants, and/or their designated representatives to create an initial, ~~revised~~, and annual plan of service (POS) after electing to receive waiver services via the Freedom of Choice Form. During this meeting, the case manager engages the applicant or participant, and all other individuals the applicant or participant would like to be involved, in the person-centered planning (PCP) process.

The case manager will meet with the applicant to develop a Plan of service (POS). The LOC assessor will offer recommendations at the conclusion of the LOC assessment. These recommendations will be presented to the participant and/or their representative for informing the PCP process. The POS is essential to ensure that the applicant/participant's needs, personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. The POS should include all services and supports that address the applicant's medical, social, educational, employment/vocational, psychological needs; access to effective communication and culturally and linguistically competent staffing; and other needs. Each plan should include specific strengths, goals, action steps, and risks, as well as the requested Medicaid and non-Medicaid services (e.g., community and faith-based services, donated items) and their associated providers.

In engaging the applicant or participant in service plan development, the case manager will provide them with service (waiver and community) information and a listing of available providers to address their needs.

Applicants, participants, and their representatives are to sign their POS prior to submission to the SMA for review to ensure the applicant/participant's health and welfare. The applicant, participant, and their representative signature indicate that they participated in, approve and understand the services outlined in the POS.

## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (4 of 8)

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

- (a) The applicant/participant, or their designated representative(s), and case manager are the primary parties involved in the plan of service (POS) development process, which occurs after an assessor from the Local Health Department (LHD), or a contractor, conducts an assessment using the interRAI Home Care (HC).
- (b) The interRAI HC tool allows the assessor to gather consistent medical, social, and environmental information for all waiver applicants/participants. Upon completing the interRAI HC, the assessor develops a plan of care (POC) to recommend services and supports to address the applicant/participant's health and welfare in the community. Upon completing the interRAI HC and POC, the assessor submits the information in the data management system, which can be accessed by the case manager. The applicant/participant can also submit additional medical documentation from their health care providers if they believe the assessment does not fully reflect their health, functional status, and/or needs.
- (c) Participants are informed of MDC services through various avenues:  
The case manager reviews the interRAI HC and POC with the applicant/participant and shares information regarding all available Medicaid waiver and State plan, as well as community services to develop the POS that meets the individual's needs. The POS includes all services and supports that address the applicant/participant's medical, social, educational, vocational, psychological, environmental, and other needs based on the applicant/participant's preferences. Each plan also includes specific strengths, goals, action steps, risks, Medicaid waiver, State plan, community services, and all the identified service providers for the services. The case manager will also seek various resources to support the applicant/participant, including, but not limited to: donated items, vocational programs, and community and faith-based services as needed.
- The case management agency will be knowledgeable about MDC and other community services and be responsible for informing applicants and participants of their choices.
- Local health departments inform participants of the service when interRAIs are conducted in the homes of individuals requesting home and community-based services. In addition to being Maryland's standardized LOC tool for certain HCBS programs, the interRAI is an assessment that assists with determining individuals needs to remain in the community.
- OLTSS website offers information regarding the MDCSW at <https://mmcp.health.maryland.gov/waiverprograms/Pages/Home.aspx>.
- ~~OLTSS publishes a Maryland Medicaid Home Community-Based Long Term Care Services pamphlet that is available to participants and their representatives. The pamphlet includes information regarding MDC services, contact numbers and the OLTSS website address. This pamphlet can be obtained in nursing facilities, hospitals, local health departments, managed care organizations, clinics and local libraries.~~
- Medical day care providers advertise the service within the communities they serve.
- (d) The participant and/or their representative are involved in the development of the POS. The POS specifically addresses participant goals, needs and preferences.
- (e) The POS meeting is scheduled at a time that is convenient for the participant and his/her family or representatives.
- (f) The case manager is responsible for the provision of waiver services. The case manager is responsible for implementing and monitoring the POS. This includes monitoring that services are being rendered in accordance to the POC. The case manager is responsible for assessing and reviewing the POS at least annually and as needed.
- (g) POS' are updated annually, or as needed, based on changes in the participant's needs or conditions.

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

X The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

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

X A specific and individualized assessed need for the modification.

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

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

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

X Regular collection and review of data to measure the ongoing effectiveness of the modification.

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

X Informed consent of the individual.

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

## **Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan**

### **Development (5 of 8)**

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs



and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The LOC assessor uses the interRAI Home Care (HC) when an individual initially applies for the waiver and annually when re-determining LOC eligibility, and as needed based on changes in a participant's health and/or functional status. The assessment captures information on the applicant/participant's medical diagnosis, health conditions, treatments and procedures, and social, functional, and cognitive/behavioral status. After an assessment is completed, the assessor recommends services and supports to address the applicant/participant's health and welfare in the community, enable him or her to avoid institutionalization, and remain as independent as possible in the least restrictive environment. The assessment occurs at the applicant/participant's residence, which allows the assessor to evaluate the risk factors associated with the applicant/participant's health and functional status as it relates to his or her current environment. Strategies to mitigate risk are incorporated into the POS, subject to participant needs and preferences. All POS must include an emergency backup plan, which identifies procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that could put the participant at risk. The backup plan should include the name and contact information for at least one back-up provider who is willing and able to provide services and supports in an emergency.

The development process for back-up plans and arrangements requires:

That all waiver service plans include a back-up plan for every waiver participant.

Each back-up plan must identify procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that would put the participant at risk.

The back-up plan should factor into the POS variables that are unique to the participant and specify actions or communication procedures that should be implemented when utilizing the back-up plan.

The backup plan should include the name and contact information for at least one back-up provider and case manager who is willing and able to provide services and supports in an emergency.

## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (6 of 8)

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

Participants may choose any approved, enrolled, and willing AMDC or case management agency from the list of approved providers. At the time of their initial LOC assessment, applicants are given a listing of all participating providers. Ongoing, participants are provided with the updated provider list upon request by the case manager, at annual meetings at minimum or they may access the provider listing on the MDH website, contact their local health department or the MDH for a listing. Participants may transfer to another center at any time. Participants will be supported in selecting a participating provider by their case manager, and can receive support from family, friends, churches or community.

As part of the plan of service (POS) development process, the case manager provides the applicant or participant with information regarding the freedom of choice of providers and shares a list of approved providers of waiver services. Additionally, the case manager, applicant/participant, and/or his or her authorized representative may contact the SMA to verify the enrollment status of a provider. If an applicant/participant is interested in the services of a provider that is not enrolled as a Medicaid waiver provider, the SMA may assist the provider with the application process to become an approved provider.

## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (7 of 8)

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

A decision is rendered by the SMA or its designee for all plans of service (POS) with the exception of POS with no change in cost, such as a change to only the selected provider. These plans with no change in frequency, duration, scope, or cost of services are auto approved directly in the LTSS Maryland Tracking System.

POS are reviewed by the SMA, MDH MDC Waiver staff for decisioning the POS. POS for waiver participants are reviewed in depth by MDH OLTSS staff during initial and annual enrollment.

## Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

*Specify the other schedule:*

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

- ☒ Medicaid agency Operating agency Case manager
- ☐ Other
- ☒ ~~Case manager~~Specify:
- ☐

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

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

## (a) Responsible parties for monitoring the implementation of the service plans:

The case management agencies are responsible for the provision of waiver services. The case manager is primarily responsible for implementing and monitoring the plan of service (POS). This includes checking in with the participant and claims reviews.

The SMA, the MDH MDC staff reviews and approves the POS and confirms the eligibility for the MDCSW.

The MDH MDC staff performs record reviews during audits to ensure the records demonstrate the POS plan was implemented and goals were accomplished. The OHCQ reports its findings to the MDH and conducts follow-up.

The MDH MDC contract monitor will perform CMA audits to ensure compliance with the MDC CMA contract.

## (b) Monitoring and follow-up methods used for POS:

1. The case manager is responsible for assessing and reviewing the plan of service at least annually or as needed to ensure the participant's needs are being met with the services and supports in the POS. The case manager will record their activities and observations in the web-based data monitoring system, LTSSMaryland. If the participant's needs require a revised POS the case manager will meet with the participant and/or their representative to develop a new POS.

Participants must also verify their continued medical, technical, and financial eligibility annually. The case manager is responsible for ensuring that there is no lapse in eligibility and that each redetermination process is completed timely. To this end, the case manager monitors the redetermination timeframes and initiates actions for each redetermination process within the data management system. Ongoing case management also includes quality monitoring and compliance with the SMA's Reportable Events (RE) Policy. Upon knowledge or discovery, the case manager must report to the SMA through the data management system designated manner any incident and/or complaint that is negatively impacting or has the potential to negatively impact a participant's health and/or welfare. Depending on the nature and severity of the incident and/or complaint, the case manager may also be required to notify law enforcement and/or Adult Protective Services (APS), and/or conduct an on-site visit to ensure the immediate wellbeing of the participant. The SMA monitors participants' health and welfare by reviewing and following up on RE, including ensuring that the intervention and action plan submitted by the case manager in response to the RE seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE. The SMA or its designee may require a corrective action plan (CAP) from providers, including case management agencies, in order to ensure that similar incidents and/or complaints do not reoccur and that the participant's health and welfare are assured. Applicants, participants, and their representatives are encouraged to sign their POS prior to submission to the SMA for review to ensure the applicant/participant's health and welfare. The applicant, participant, and their representative signature indicate that they participated in, approve and understand the services outlined in the POS.

2. The MDH OLTSS staff monitor service plans during the initial and annual review of applicants and participants eligibility for the MDC. The scope of MDH's review includes verifying services included in the POS meet the participant needs and has been approved by the participant and/or their authorized representative.

MDH OLTSS staff also conducts annual reviews of MDC participants' records that include POS. A statistically valid sample size with a confidence level of 95 percent, plus or minus 5 of participant records are reviewed for appropriate documentation and proper monitoring of service plans. The scope of MDH's review includes ensuring services are furnished in accordance with the service plan, participant access to waiver services, effectiveness of back-up plans, and participant access to non-waiver services identified in the service plan. A report of findings will be issued and the case management agency will have an opportunity to identify actions to remediate identified problems via a submission of a corrective action plan within 15 business days.

3. The Freedom of Choice Consent forms are required to be signed by the participant upon initial enrollment and annually during the annual redetermination process.

b. Monitoring Safeguards. *Select one:*

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

☐

**Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver**

services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.

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

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

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

#### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**SP PM1: % of participants' plans that address the assessed needs including health and safety risk factors; Numerator: # of plans reviewed that address the assessed needs including health and safety requirements; Denominator: # of plans reviewed.**

**Data Source (Select one):**

**Record reviews, ~~on-site~~off-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div>95+-5</div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

**SP PM2: % of participants' plans that address their personal goals; Numerator: # of plans that reflect the participants personal goals; Denominator: # of plans reviewed.**

**Data Source** (Select one):

**Record reviews, ~~on-site~~off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95+-5
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>



<input checked="checked" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
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<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**b. Sub-assurance:** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

#### Performance Measures

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

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

#### Performance Measure:

SP PM3: % of Service plans that are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual. Numerator: # of Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual. Denominator: # of service plans reviewed.% of participants' service plans updated/revised at least annually; Numerator: # of participants' service plans that have been updated or revised; Denominator: # of participants' service plans reviewed.

#### Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95+-5</div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

#### Performance Measures

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

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

#### Performance Measure:

**SP PM4: % of participants with services delivered in accordance with their service plan including the type, scope, amount, duration and frequency of services; Numerator: # of sampled participants with services delivered in accordance with their service plan; Denominator: # of sampled participants**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative
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		<b>Sample</b> Confidence Interval = <div>95 + -5</div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <del>X</del> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuous y and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>

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

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

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

**Performance Measure:**

**SP PM5: % of participants who received the list of medical day care providers when enrolled in the waiver; Numerator: # of participants who received the list of medical day care providers;**

**Denominator: # of Medical Day Care Services Waiver participants enrolled**

**Data Source (Select one):**

Record reviews, **off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> <del>X</del> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuous and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other	

	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure**

SP PM6: % of participants where service plans were developed in accordance with its policies and procedures.  
Numerator: # of participants where service plans were developed in accordance with its policies and procedures.  
Denominator: # of participants' service plans reviewed.

**Data Source (Select one):**

Record reviews, ~~on~~off-site

If 'Other' is selected, specify:



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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div>95+-5</div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- 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.

The SMA or its designee, monitor compliance with the above assurances through reports built into the LTSS Maryland Tracking System and, when needed, generate custom reports. These reports allow the SMA to evaluate the timelines associated with the development and review of plans of service (POS) and compliance by the case management agencies with respect to program requirements pertaining to changes in participants' needs. If deficiencies are identified, the SMA will request a corrective action plan (CAP) from the case management agency delineating how, and the timeframe in which, the deficiencies will be remediated.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When the State discovers that a participant's assessed needs were not included in the POS, an updated POS is requested within 15 business days addressing the issue. The updated POS will be approved or disapproved by the State. When appropriate, funds will be recovered.

When the State discovers that a participant's POS is not in accordance with the POS requirements, a corrective action plan is requested from the CMA within a timeframe appropriate to the issue cited. The corrective action plan is approved or disapproved. Once approved, an updated POS is required to be submitted to the State to ensure the corrective action has been implemented. When appropriate, funds will be recovered.

When the State discovers that a participant's POS was not approved by the participant or their authorized representative, a corrective action plan is requested from the CMA and an approved POS must be submitted within a timeframe appropriate to the issue cited. Funds will be recovered for the period the case management agency was out of compliance.

When the State discovers that a participant's POS was not updated/ revised at least annually or when the participant's needs changed, a corrective action plan is requested from the CMA and an updated POS must be submitted within a timeframe appropriate to the issue cited. When appropriate, funds will be recovered.

When the State discovers services were not delivered in accordance with the POS, a corrective action plan is requested from the CMA and an updated POS must be submitted within a timeframe appropriate to the issue cited. When appropriate, funds will be recovered for the time period when CMA were out of compliance.

If there is an oversight, omission or error on a participant Consent Form, the State requests that the form be corrected.

When the State discovers a participant was not given a list of medical day care providers, a list will be sent to the participant to provide the opportunity for them to choose a medical day care facility. The State will contact the CMA to determine whether the distribution protocol is being followed. If not, corrective action will be requested within 15 business days.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

## c. Timelines

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

☒ No ☐ Yes

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

~~End of January 2023:~~

~~Start scoping sessions to enhance the OL TSS plan of care tracking system, LTSS Maryland; Respond to CMS input/feedback regarding timeline and updated waiver application; Prepare TCM/ASO for posting and subsequent Q&A meetings; Post solicitation for 90 days and share posting of solicitation with other Chiefs to share with networks; Complete the renewal for the~~

~~1915(e) (contingent on CMS response time); and~~

Prepare 7th extension request, if necessary, before 12/22/22. End of February 2023:

~~Review and update regulations to include case management components – prepare for release of AELR hold at the end of session;~~

~~Hire and train additional internal OLTSS staff, if approved for additional positions; Begin preparing training materials for MDC providers;~~

~~Begin preparing training materials for case management agencies; and Ensure MDC case management procedure codes are set up for billing.~~

The following safeguards are in place:

1. Case Management is provided as a direct waiver service and includes the monitoring of plan of service (POS) implementation and participant health and welfare.

2. All initial and annual POS are reviewed and must be approved by the SMA or its designee.

3. The SMA conducts ongoing monitoring of its case management agencies to ensure POS development and implementation are done according to the current solicitation and any other program requirements.

~~Providers identified through a solicitation process will provide case management services to applicants and participants of the MDCSW. Within this agreement it is established that providers must meet all requirements outlined within the conflict-free modality operated by the Department, including the disclosure and reporting of any real or perceived conflict of interest, meaning any real or perceived incompatibility between any agency or agency employee's private interests and duties of the solicitation.~~

~~In addition, the provider must submit to the Department for approval, staffing standards, and qualifications for all roles to ensure adequate education, training, and/or experience. Providers must also develop and submit to the Department for approval, a training plan that includes a process for evaluating the competency of staff and the efficacy of the training. All case managers attend Department training for new providers; the training must be completed prior to the provider rendering services.~~

~~Compliance with requirements by case management providers is monitored on an annual basis by the Department. All providers are responsible for informing applicants/participants of all services available, their right to choose from and among all willing and qualified providers that are part of the provider network and report any knowledge of behavior that would violate conflict-free case management or that would interfere with the right of a participant to have free choice of providers. Providers are not permitted to provide other direct waiver services that are part of a participant's plan of services.~~

~~The participant leads the development of their Plan of Service (POS). Case managers are responsible for engaging the applicant or participant and their representative in the PCP POS development process. During the POS development process, the case manager informs the applicant or participant and the representative of their available choice to select services and providers.~~

~~Each plan must include specific strengths, goals, action steps and risks, emergency backup providers, as well as the requested Medicaid (waiver and state plan) and non-Medicaid services (e.g., community and faith-based services, donated items) and their associated providers to support the health and welfare of the applicant/participant.~~

~~Applicants, participants, and their representatives are encouraged to sign their POS prior to submission to the SMA for review to ensure the applicant/participant's health and welfare. The applicant, participant, and their representative signature indicate that they participated in, approve and understand the services outlined in the POS.~~

~~An allegation of or an actual occurrence of an incident that adversely and/or has the potential to negatively affect the health, safety, and welfare as well as, quality of care or service issue complaints of an applicant/participant can be submitted via a Reportable Event (RE). The RE process is used to monitor and remediate allegations and incidents. A RE includes: A analysis of information from the RE is used to address concerns which may result in an enhanced coordination of program services and consolidated processes.~~

## Appendix E: Participant Direction of Services

**Applicability** (from Application Section 3, Components of the Waiver Request):

- ☐ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☒ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- ☐ **Yes. The state requests that this waiver be considered for Independence Plus designation.** ☐ **No. Independence Plus designation is not requested.**

### Appendix E: Participant Direction of Services E-1: Overview (1 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (2 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (3 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (4 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (5 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (6 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### Appendix E: Participant Direction of Services E-1: Overview (7 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (8 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services E-1: Overview (9 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services E-1: Overview (10 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services E-1: Overview (11 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services E-1: Overview (12 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services E-1: Overview (13 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant Direction (1 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (2 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (3 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (4 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

## E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

### Appendix E: Participant Direction of Services

## E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

### Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid provides broad fair hearing rights and appeal rights to individuals who are denied participation of HCBS waiver services as an alternative to institutional care, denied services of their choice, and whose services are suspended, reduced, or terminated. Specifically, COMAR 10.01.04, which governs fair hearings, stipulates that the opportunity for a fair hearing will be granted to individuals who receive an adverse decision from the Department or a designated agency.

Applicants are given a written copy of the Summary of Procedures for Fair Hearings. This document explains the applicant's right to appeal within 90 days from the date of their notice, what information to include in the appeal letter, who to contact if assistance is needed when filing an appeal and how to prepare for the hearing. In addition, the Summary of Procedures for Fair Hearings informs the applicant who they may contact if he/ she wishes to obtain legal aid services that are of no cost to the individual.

The participant and any authorized representative are sent a letter that contains the reason for the adverse action and a copy of the Summary of Procedures for Fair Hearings. The summary explains that the participant must file an appeal within 10 days from the date of the denial notice in order to ensure continuation of services pending a fair hearing decision. The participant has 90 days from the date of the notice to file the appeal; however, continuation of benefits will not be received unless the participant files within the 10-day timeframe.

The participant will receive a letter advising that their services will continue as a result of filing an appeal within 10 days of receipt of the denial notice. The participant will receive a letter advising that services will not continue as a result of an untimely appeal filing outside of the 10-day timeframe. An applicant denied entry into the waiver do not receive services pending the outcome of the OAH hearing.

Copies of the adverse action letters with fairing hearing language are maintained in the LTSSMaryland.

### Appendix F: Participant-Rights

## Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

☒ **No. This Appendix does not apply**



☐ Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

☐ No. This Appendix does not apply

☒ Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The MDH and OHCQ oversee the operation of the complaint system. The SMA is responsible for the operation and oversight of the incident reporting and management system in accordance with its Reportable Events (RE) Policy, which also provides a mechanism for participants to register complaints.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants and/or their representatives may lodge grievances/complaints regarding any aspect of the participant's services and supports. Grievances/complaints can be made directly to the SMA, case manager, Local Health Department (LHD) ~~nurse monitor~~, or any other provider of waiver services.

Participants are informed of the process to file a grievance or complaint (reportable event) without filing a Fair Hearing during initial enrollment and during their discussions with the case manager. Participants and/or their representatives may make a verbal or written complaint. It is the primary responsibility of the case manager to enter the complaint ~~in accordance with Department policy into the reportable events (RE) module of the data management system~~ although the SMA may also enter the complaint, particularly if the case manager is indicated in the complaint. The case manager must develop and submit an intervention and action plan, which will resolve the complaint, within 10 business days of knowledge or discovery of the complaint.

The mechanisms used to resolve complaints depend on the nature of the complaint. Participants may decide to request a change in a provider, including the case manager if they are not satisfied with the services provided or do not feel that they are being treated with respect. If the complaint concerns the case manager, the SMA works with the agency supervisor to determine if the complaint can be resolved or if the assignment of a new case manager is appropriate. If the complaint is about a provider other than the case manager, the case manager serves as the lead in working with the participant on obtaining a change.

If a complaint indicates that a provider is providing poor quality services, failing to provide services, or being disrespectful to the participant, the information from the RE is shared with appropriate SMA staff for follow-up and appropriate action, such as initiating a corrective action plan (CAP). The RE may also be referred outside of the SMA for further investigation and possible sanctions, including the Office of Health Care Quality (OHCQ), Maryland Board of Nursing (MBoN), and/or Adult Protective Services (APS).

(a) All entities associated with the waiver program are required to report the event including: case managers, providers, waiver participants and their family members and State administrators. Reporting requirements and timeframes are based on the nature of the event/complaint and are specified in the OLTSS Reportable Event Policy.

(b) All written reportable events must be completed and submitted within 7 calendar days of the event. For Immediate Jeopardy cases, a telephone referral must be made within 24 hours of the event.

The ~~SMA Program~~ reviews the event and takes appropriate action to protect participants from harm.

MDH compiles reportable event data ~~quarterly~~~~daily~~. MDH submits quarterly reports to the Medical Day Care Services Advisory Committee.

Grievances/complaints related to State mandated quality of care standards applicable to all consumers of adult medical day care irrespective of payment source are received by or referred to OHCQ for investigation. Grievances/complaints related to the provision of Medicaid services are investigated by MDH OLTSS staff either independently or in conjunction with OHCQ.

Grievances and complaints will be investigated and addressed in accordance with the OLTSS Reportable Event Policy.

(c) Mechanisms used to resolve grievances/complaints in the Reportable Event system are described below.

The reportable event process is not a substitute for the Fair Hearing process. If a complaint or grievance is filed with the MDH and an adverse decision is made, the participant is advised of their Fair Hearing rights and Summary of Procedures for Fair Hearing in writing.

The MDH OLTSS staff receive all reportable events, log all events into a Reportable Event database ~~or LTSS Maryland~~ and provide follow-up. All reportable events must be completed and reported within 7 calendar days of the event, unless the event is considered one that puts the individual in imminent danger, known as immediate jeopardy. MDC providers must report known cases of abuse, negligence, or exploitation within 24 hours. These cases should also be reported immediately to Adult Protective Services, OHCQ, and the local law enforcement agency. Investigations are conducted by these entities and MDH requests the outcome of the investigation. When appropriate, the participant and his/ her representative are notified of the results of the investigation reported to the MDH. The outcomes are received, and logged, the case is closed, unless additional follow-up is required.

The MDH OLTSS staff must initiate an onsite survey/investigation within 2 business days of the telephone referral, in order to address the cases of abuse, negligence, or exploitation.

Follow-up and intervention is required by the MDH for all other reportable events within 7 calendar days of receipt of the event. The follow up action plan must also be completed within 7 calendar days from receipt of the event. A complaint status letter must be sent within 7 calendar days of the MDH review. The complaint or incident must be resolved within 45 calendar days.

The MDH OLTSS staff are responsible for overseeing the reporting of and response to critical incidents or events. The MDH OLTSS staff compile reportable event data daily and a log is maintained documenting actions taken to resolve critical issues and/or complaints. The MDH OLTSS staff compile a Quarterly Summary Report of all events and make specific recommendations for program, policy, or procedure changes.

The MDCSW Advisory Committee meets quarterly to review and analyze reportable event data, policy, and procedures. Committee members share experiences and identify problem areas. Collectively, the Committee helps develop remediation strategies for problems and further refine the waiver's quality assurance management system. The Committee provides consultation and feedback when system design changes are necessary to improve the effectiveness of a waiver's quality improvement strategy.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

~~Types of critical events~~—A reportable event includes an allegation of or an actual occurrence of an incident that adversely and/or has potential to negatively affect the health, safety, and welfare of an individual, as well as quality of care or service issue complaints. Reportable events may include an allegation of or actual occurrence of any of the following: Abuse, accidents/injuries, exploitation, neglect/self-neglect, treatment errors, rights violations, or any other incidents or complaints not specified above.

All entities associated with the waiver program are required to report the event including: case managers, providers, waiver participants and their family members and State administrators. Reporting requirements and timeframes are based on the nature of the event/complaint and are specified in the OLTSS Reportable Event Policy.

Incidents and complaints are reported on Medicaid's Home and Community Based Services Reportable Event form. Sections of the form include information regarding the reporter and the person completing the form; event information; description of the incident and response; agency contact check off; and intervention and action plan description. The form is submitted via designated fax, email and/or LTSSMaryland.

All reportable events must be completed and submitted within 7 calendar days of the event. For immediate jeopardy cases, a telephone referral must be made within 24 hours of the event.

The Program reviews the event and takes appropriate action to protect the participant from harm.

The MDH OLTSS staff compile reportable event data daily. Staff submits quarterly reports to the MDCSW Advisory Committee.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers are responsible for providing participants and their representatives with information about identifying and reporting incidents that are adversely affecting, or have the potential to adversely affect, the participant's health and/or welfare, including allegations of abuse, neglect, and/or exploitation. During the initial and annual plan of service (POS) development process, the case manager must document that the participant has been provided information on how to report abuse, neglect, and/or exploitation. Participants surveyed through the annual quality survey are asked about whether they know how to report allegations of abuse, neglect, and/or exploitation and these data are used to inform continuous quality improvement activities.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

All waiver providers are required to report REs upon knowledge or discovery. ~~Thus, the remainder of providers report incidents and complaints directly to the MDH OLTSS staff who receive all other reportable events, log all events into a Reportable Event database and provide follow up to the case managers.~~ All reportable events must be completed and reported within 7 calendar days of the event. MDC providers must report known cases of abuse, negligence, or exploitation within 24 hours. These cases should also be reported immediately to APS, OHCQ, and the local law enforcement agency. Investigations are conducted by these entities and MDH OLTSS staff request the outcome of the investigation. When appropriate, the participant and his/ her representative are notified of the results of the investigation reported to the MDH OLTSS staff.

If the incident is defined as one of immediate jeopardy (IJ), the timeframe for submission is different. An IJ incident is defined as one that presents actual harm or an immediate and serious threat of injury, harm, impairment, or death to a participant. In cases of an IJ incident, the case manager must submit the RE ~~in the LTSS Maryland Tracking System~~ within 24 hours of knowledge or discovery. The case manager must also take the appropriate immediate actions to safeguard the participant, including, as appropriate, notification to law enforcement and/or Adult Protective Services (APS). The case manager must also conduct an on-site visit within one (1) business day of submission of the IJ RE if the participant may still be in jeopardy. All waiver providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to APS and/or law enforcement.

The case manager must also develop and submit an intervention and action plan, which will resolve the incident and/or complaint, within ~~5+0~~ business days of knowledge or discovery of the incident and/or complaint. The intervention and action plan seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE.

Depending on the nature of the incident or complaint reported ~~through the incident management system~~, the participant or ~~his/her/their~~ representative is kept abreast of developments via the assigned case manager. There are specific time frames in which the case manager has to report an incident or complaint to the State Medicaid Agency (SMA) and in which the case manager has to develop and submit the intervention and action plan. These time frames are noted in this section.

When the nature of the incident is such that it must be referred to an outside agency for investigation and, if applicable, additional action, the participant or ~~his/her/their~~ representative is most often informed directly by law enforcement and/or Adult Protective Services (APS) about the outcome of the investigation. In some cases, the case manager is also informed and will serve as a liaison between the participant or his/her representative. Any allegations of abuse, neglect and/or exploitation must be reported to law enforcement and/or APS within 24 hours of knowledge or discovery. The SMA strives to complete its comprehensive review, including implementation of the identified intervention(s) and any referrals to outside agencies within 45 days.

All waiver providers are required to report RE upon knowledge or discovery. ~~Thus, the remainder of providers report incidents and complaints directly to the MDH OLTSS staff who receive all other reportable events, log all events into a Reportable Event database and provide follow up to the case managers.~~ All reportable events must be completed and reported within 7 calendar days of the event. MDC providers must report known cases of abuse, negligence, or exploitation within 24 hours. These cases should also be reported immediately to APS, OHCQ, and the local law enforcement agency. Investigations are conducted by these entities and MDH OLTSS staff request the outcome of the investigation. When appropriate, the participant and his/ her representative are notified of the results of the investigation reported to the MDH OLTSS staff.

If the incident is defined as one of immediate jeopardy (IJ), the timeframe for submission is different. An IJ incident is defined as one that presents actual harm or an immediate and serious threat of injury, harm, impairment, or death to a participant. In cases of an IJ incident, the case manager must submit the RE ~~in the LTSS Maryland Tracking System~~ within 24 hours of knowledge or discovery. The case manager must also take the appropriate immediate actions to safeguard the participant, including, as appropriate, notification to law enforcement and/or Adult Protective Services (APS). The case manager must also conduct an on-site visit within one (1) business day of submission of the IJ RE if the participant may still be in jeopardy. All waiver providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to APS and/or law enforcement.

The case manager must also develop and submit an intervention and action plan, which will resolve the incident and/or complaint, within ~~5+0~~ business days of knowledge or discovery of the incident and/or complaint. The intervention and action plan seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE.

Depending on the nature of the incident or complaint reported through the incident management system, the participant or his/her representative is kept abreast of developments via the assigned case manager. There are specific time frames in which the case manager has to report an incident or complaint to the State Medicaid Agency (SMA) and in which the case manager has to develop and submit the intervention and action plan. These time frames are noted in this section. When the nature of the incident is such that it must be referred to an outside agency for investigation and, if applicable, additional action, the participant or his/her representative is most often informed directly by law enforcement and/or Adult Protective Services (APS) about the outcome of the investigation. In some cases, the case manager is also informed and will serve as a liaison between the participant or his/her representative. Any allegations of abuse, neglect and/or exploitation must be reported to law enforcement and/or APS within 24 hours of knowledge or discovery. The SMA strives to complete its comprehensive review, including implementation of the identified intervention(s) and any referrals to outside agencies within 45 days.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The MDH OLTSS staff are responsible for overseeing the reporting of and response of critical incidents or events. The MDH OLTSS staff compile reportable event data weekly and a log is maintained documenting actions taken to resolve critical issues and/or complaints. The MDH OLTSS staff compile a Quarterly Summary Report of all events and make specific recommendations for program, policy, or procedure changes.

The MDCSW Advisory Committee meets quarterly to review and analyze reportable event data. Committee members share program experiences and identify problem areas. Collectively, the Committee will help develop remediation strategies for problems and may provide feedback that assist with refining the waiver's quality assurance management system.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☐ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

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☒ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State does not permit seclusion within an MDC. This is prohibited in accordance with COMAR 10.12.04.13. The State has included the following language in the application. The Office of Health Care Quality (OHCQ) is responsible for detecting unauthorized use of restraints. The OHCQ performs investigations of reports of restraint use as well as detects unauthorized restraint use during site visits. In accordance with Title 10 MARYLAND DEPARTMENT OF HEALTH Subtitle 12 ADULT HEALTH Chapter 04 Day Care for the Elderly and Adults with a Medical Disability Authority: Health-General Article, §2-104, 14-206, and 14-304; State Government Article, §10-226; Annotated Code of Maryland, seclusion is prohibited.

State licensure law for Day Care for the Elderly and Adults with a Medical Disability requires that the MDC provider must have a policy and procedure on the use of any device or medication for the specific purpose of secluding (if applicable) a participant or restraining the participant's freedom or motion or movement within the center.

The State regulations for the use of restraints require a prescribed physician order. The type of restraint permitted is determined by the physician. The use of restraints must be for a medical reason and shall be implemented in the least restrictive manner possible and may not be written pro re nata/ PRN (as needed) or used for staff convenience. The physician orders must specify the following:

- (1) The purpose of the restraint;
- (2) The type of restraint to be used;
- (3) The length of time the restraint shall be used;
- (4) The period of time the restraint order is in effect; and
- (5) Alternative methods to avoid the use of restraints.

The authorization of restraints must be documented in the participant's plan. When restraints are employed, the occurrence must be documented in the nursing notes. The OHCQ conducts a survey prior to licensure and every 2 years thereafter. During the survey, MDC's records and procedures are reviewed to determine the unauthorized use of restraints. When it is discovered that an unauthorized use of restraints has occurred, an investigation is conducted. Unauthorized use of restraints may also be reported to the OHS by the participant, provider staff, family members or advocacy groups through the Reportable events process.

To ensure the health and safety of individuals, the following protocols must be adhered to when restraints are employed:

1. "As-needed" restraint orders are not permitted, a provider must first employ alternative non-aversive methods such as one-on-one observation, walking, talking, and diverting attention prior to recommending restrictive interventions. These methods and recommendations must be documented.
2. Orders for the use of a restraint shall be time specific.
3. A participant shall not remain in a restraint for more than 2 hours without a change in position and toileting opportunity.
4. If an order for the use of a restraint is to be continued, the order shall be renewed at least every 7 days by a physician.
5. Chemicals or drugs may not be used for participants in the following ways:
  - (a) In excessive dose, including duplicate drug therapy;
  - (b) For excessive duration, without adequate monitoring;
  - (c) Without adequate indications for its use; or
  - (d) In the presence of adverse consequences which indicate the dose should be reduced or discontinued.
6. Participants may not be physically restrained:
  - (a) For discipline or convenience; or
  - (b) If a restraint is not ordered by a physician to treat the participant's symptoms or medical conditions.
7. The health care practitioner shall provide training to staff in the appropriate use of the restraint ordered by the physician. The education and training needed by personnel involved in the administration of restraints are specific to the participant's needs. The education and training needed is documented in the participant's plan.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of



restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

OHCQ is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed. The OHCQ conducts a survey prior to licensure and every 2 years thereafter. During on site surveys, OHCQ reviews the MDC provider's records and procedures to ensure that the use of restraints are prescribed for medical reasons and are implemented in the least restrictive manner possible. Restraints are authorized by a physician and documented in the participant's plan. When restraints are employed, the occurrence must be documented in the nursing notes. When inappropriate uses of restraints are reported to OHCQ or OHS, an investigation is initiated by the OHCQ.

Inappropriate use of restraints may be reported to the OHCQ or OHS by the participant, provider staff, family members or advocacy groups through the Reportable Events process. If inappropriate use of restraints is identified during a survey or investigation, the OHCQ will initiate actions based on the findings. Remedial actions may include but are not limited to requiring a plan of correction, monetary sanctions and licensure suspension or revocation. When a provider has been cited, the OHCQ conducts additional reviews to ensure compliance. The OHCQ shares all reports, findings and remediations with OHS through telephone discussions, emails, inter-office mail and meetings. This is an ongoing process. If there is a problem or there is no remediation the OHCQ and OHS discuss strategies necessary to ensure the inappropriate use of restraints is discontinued. Strategies employed may include recommending policy changes, additional reviews, monetary penalties or recommending that law enforcement become involved.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

#### b. Use of Restrictive Interventions. *(Select one):*

☐ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

☒ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State regulations for the use of restraints require a prescribed physician order. The type of restraint permitted is determined by the physician. The use of restraints must be for a medical reason and shall be implemented in the least restrictive manner possible and may not be written pro re nata/ PRN (as needed) or used for staff convenience. The physician orders must specify the following:

- (1) The purpose of the restraint;
- (2) The type of restraint to be used;
- (3) The length of time the restraint shall be used;
- (4) The period of time the restraint order is in effect; and
- (5) Alternative methods to avoid the use of restraints and seclusion.

The authorization of restraints must be documented in the participant's plan. When restraints are employed, the occurrence must be documented in the nursing notes. The OHCQ conducts a survey prior to licensure and every 2 years thereafter. During the survey, MDC's records and procedures are reviewed to determine the unauthorized use of restraints. When it is discovered that an unauthorized use of restraints has occurred, an investigation is conducted. Unauthorized use of restraints may also be reported to the OHS by the participant, provider staff, family members or advocacy groups through the Reportable events process.

To ensure the health and safety of individuals, the following protocols must be adhered to when restraints or seclusions are employed:

1. "As-needed" restraint orders are not permitted, a provider must first employ alternative non-aversive methods such as one-on-one observation, walking, talking, and diverting attention prior to recommending restrictive interventions. These methods and recommendations must be documented.
2. Orders for the use of a restraint shall be time specific.
3. A participant shall not remain in a restraint for more than 2 hours without a change in position and toileting opportunity.
4. If an order for the use of a restraint is to be continued, the order shall be renewed at least every 7 days by a physician.
5. Chemicals or drugs may not be used for participants in the following ways:
  - (a) In excessive dose, including duplicate drug therapy;
  - (b) For excessive duration, without adequate monitoring;
  - (c) Without adequate indications for its use; or
  - (d) In the presence of adverse consequences which indicate the dose should be reduced or discontinued.
6. Participants may not be physically restrained:
  - (a) For discipline or convenience; or
  - (b) If a restraint is not ordered by a physician to treat the participant's symptoms or medical conditions.
7. The health care practitioner shall provide training to staff in the appropriate use of the restraint ordered by the physician. The education and training needed by personnel involved in the administration of restraints or seclusion are specific to the participant's needs. The education and training needed is documented in the participant's plan.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

OHCQ is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed. The OHCQ conducts a survey prior to licensure and every 2 years thereafter. During on site surveys, OHCQ reviews the MDC provider's records and procedures to ensure that the use of restraints are prescribed for medical reasons and are implemented in the least restrictive manner possible. Restraints are authorized by a physician and documented in the participant's plan. When restraints are employed, the occurrence must be documented in the nursing notes. When inappropriate uses of restraints are reported to OHCQ or OHS, an investigation is initiated by the OHCQ.

Inappropriate use of restraints may be reported to the OHCQ or OHS by the participant, provider staff, family members or advocacy groups through the Reportable Events process. If inappropriate use of restraints is identified during a survey or investigation, the OHCQ will initiate actions based on the findings. Remedial actions may include but are not limited to requiring a plan of correction, monetary sanctions and licensure suspension or revocation. When a provider has been cited, the OHCQ conducts additional reviews to ensure compliance. The OHCQ shares all reports, findings and remediations with OHS through telephone discussions, emails, inter-office mail and meetings. This is an ongoing process. If there is a problem or there is no remediation the OHCQ and OHS discuss strategies necessary to ensure the inappropriate use of restraints is discontinued. Strategies employed may include recommending policy changes, additional reviews, monetary penalties or recommending that law enforcement become involved.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☒ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State does not permit seclusion within an MDC. This is prohibited in accordance with COMAR 10.12.04.13. The State has included the following language in the application. The Office of Health Care Quality (OHCQ) is responsible for detecting unauthorized use of restraints. The OHCQ performs investigations of reports of restraint use as well as detects unauthorized restraint use during site visits. In accordance with Title 10 MARYLAND DEPARTMENT OF HEALTH Subtitle 12 ADULT HEALTH Chapter 04 Day Care for the Elderly and Adults with a Medical Disability Authority: Health-General Article, §2-104, 14-206, and 14-304; State Government Article, §10-226; Annotated Code of Maryland, seclusion is prohibited.

The OHCQ licensing surveyors and investigators are responsible for reviewing and identifying potentially harmful practices at medical day care facilities. OHCQ, as the licensing regulatory authority, follows up with providers when harmful or potentially harmful practices are identified as a "serious or immediate threat." Depending on the severity of the issue, OHCQ's administrative staff may request a civil money penalty, an immediate corrective action plan from the provider, or issue a directed plan of correction which informs the provider of specific practices and policies which must be put into place within a specified time frame to prevent future "serious or immediate threats."

☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

- ☐ **No. This Appendix is not applicable** (*do not complete the remaining items*)
- ☒ **Yes. This Appendix applies** (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

COMAR 10.12.04.17 requires that each MDC provider have written policies for the facility that shall specify that the RN, LPN, or CMT is authorized to procure, receive, control, and manage the administration of medications at the center. Medicine or drugs shall be restricted to those prescribed for the participant by the authorized prescriber. All medications shall be accurately and plainly labeled and kept in the original container issued by the prescriber or pharmacist. Containers shall be labeled with the:

- (a) Participant's full name;
- (b) Authorized prescriber;
- (c) Prescription number;
- (d) Name of the medication and dosage;
- (e) Date of issuance;
- (f) Expiration date;
- (g) Refill limits;
- (h) Directions for use.

The registered nurse or the licensed practical nurse may not package, repackage, bottle or label, in whole or in part, any medication in any way by tampering or defacing any label medication, except that a registered nurse or licensed practical nurse may take medication from pharmacy dispensed containers and placed the medication in a pill box for the cognitively intact participant who lives independently to self-administer.

The facility must provide a safe, secure, locked place for prescribed and over-the-counter type medications or supplements. Schedule II drugs must be kept in a locked box within a medicine cabinet and medications requiring refrigeration must be in a separate locked refrigerator or a locked box within a medication refrigerator. Prescribed and over-the-counter type medications, supplements and medical supplies must be secured or stored apart from participant activity areas, food storage areas, and chemical storage areas.

A registered nurse or licensed practical nurse shall inspect the drug storage conditions at least every 3 months and document his or her findings. Orders shall be reviewed and updated in a timely manner, consistent with nursing practice standards, when there is a change in the participant's condition. Additionally, in accordance with COMAR 10.09.07.03 N, the facility must have in place a quality assurance plan, that at a minimum, evaluates the provided services and the proficiency of the services provided.

OHCQ monitors whether a plan of correction is being implemented when a renewal survey is due, at least every 2 years. This is for all type of deficiencies. If a Provider is under sanction, then the level of monitoring increases based on sanction requirements.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

- a) The OHCQ surveyors and investigators are responsible to review for and identify potentially harmful practices at the MDC facility. OHCQ staff review the actions of facility staff to dispense and store medications as well as the responsibility of facility staff to assess the participant's ongoing ability to self-medicate.
- b) OHCQ follows-up with providers when harmful or potentially harmful practices are identified. Depending on the severity of the problem, OHCQ staff may request a corrective action plan from the provider or issue a Directed Plan of Correction which informs the provider of specific practices and policies which must be put into place within a specified time frame.
- c) The OHCQ is responsible for follow-up and oversight. The OHCQ surveyors or investigators review residents' medication regimens during their periodic inspections and when a complaint is received about medication administration, safety or storage. The OHCQ staff follow-up on provider non-compliance by requiring corrective action plans.

When the OHS LTSS staff receive a reportable event concerning medications, the problem is reported to OHCQ and/or the Maryland Board of Nursing. The OHS LTSS staff document the follow-up actions of OHCQ and/or the Maryland Board of Nursing in the LTSSMaryland. When warranted, additional monitoring and/or a recovery may be initiated by the OHS LTSS staff.

Monitoring is performed through surveys that are conducted at least once every 2 years or through incident reporting. Prior to a Surveyor going out to conduct the survey or complaint/incident investigation, they review past deficiencies and plans of correction, as well as any sanctions that may be in effect. When the Surveyor is onsite conducting the survey or complaint/incident investigation, they determine if the provider is following through with any plan of correction or sanctions they have in place. When the survey or complaint/incident investigation is complete, a SOD is created and submitted to the provider. If deficiencies are cited, the provider is required to complete a plan of correction within 10 calendar days that addresses the deficient practice. The plan of correction is reviewed for it being reasonable and credible: Does the plan of correction correct the problem?

What is the monitoring plan? Who is responsible and the timeframe? For remediation, once the plan of correction has been deemed reasonable and credible, follow-up is conducted to ensure the corrective actions have been implemented. If the corrective actions have not been implemented, a follow-up plan of correction is requested or adverse action is initiated.

If deficiencies cited are repeat deficiencies from the last survey conducted, then the Surveyor will review the plan of correction to ensure that provider plan of correction language is not a duplicate of their last plan of correction. If the corrective actions are not acceptable, an updated plan of correction is requested or adverse action is initiated.

Data acquired during surveys and complaint/incident investigations are entered into a database, which creates queries and reports that are used to help identify trends and patterns. This information is critical in identifying systemic issues for which targeted surveys can be conducted. The data are shared with Medicaid advisory committees, industry associations, and with individual providers through the plan of correction process. The data are also used to assist with developing policies, procedures and regulations.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

- ☐ Not applicable. *(do not complete the remaining items)*
- ☒ Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

##### ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or

waiver provider responsibilities when participants self-administer medications, including (if applicable) policies

concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

OHCQ licensing regulations require facilities to maintain records of all written orders and Schedule II drugs. Medications may not be administered without a written order that has been signed by the authorized health care provider. Medications may only be administered based upon a verbal order when the verbal order has been recorded and signed by the RN or the LPN. Verbal orders shall be signed by the authorized health care provider within 30 calendar days. Only a registered nurse, licensed practical nurse, or an authorized health care provider shall give injectable medication.

For those participants who are not capable of self-medicating, the individual assigned the responsibility of administering medications shall prepare the dosage; observe the participant swallowing the oral medication; and document that the participant has taken the medication. Staff members who are licensed and certified to administer medications shall make a written record of the medications and treatments that are administered. When a RN or LPN observes an adverse reaction to a medication, the nurse must immediately call the participant's health care provider, designee of the participant's health care provider, or the health care provider that is on call for the center.

**iii. Medication Error Reporting.** *Select one of the following:*

☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors must be reported to OHCQ and the OHS LTSS in accordance with the Reportable Event Policy.

(b) Specify the types of medication errors that providers are required to *record*:

All medication errors are to be recorded by facility staff in accordance with their quality assurance plan. Additionally, under the OHS Reportable Events Policy, medication errors are to be reported to both the OHS LTSS and OHCQ staff.

(c) Specify the types of medication errors that providers must *report* to the state:

The OLTSS Reportable Events Policy requires that any medication error resulting in a need for medical care beyond the level of basic first aid be reported to MDH OLTSS and OHCQ staff.

☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.



The OHCQ has a dedicated surveyor unit which surveys and licenses medical day care facilities. Surveying may be conducted annually or every two years depending on the compliance record of the facility. Complaints made to OHCQ are investigated as soon as feasible based on the nature of the complaint/s.

After OHCQ completes a licensing or complaint survey/investigation, electronic copies are available for OHS LTSS staff review. OHCQ will contact the OHS LTSS staff by email or phone in the event of a serious problem, including problems concerning medication administration or oversight. OHCQ surveys include a review of medication administration documentation and staff credentials to ensure appropriate staff are administering medications.

Monitoring methods include surveys and complaint/incident investigations. If deficiencies are cited, the provider is required to complete a plan of correction within 10 calendar days that addresses the deficient practice. The plan of correction is reviewed for it being reasonable and credible: Does the plan of correction correct the problem? What is the monitoring plan? Who is responsible and the timeframe? For remediation, once the plan of correction has been deemed reasonable and credible, follow-up is conducted to ensure the corrective actions have been implemented. If the corrective actions have not been implemented, a follow-up plan of correction is requested or adverse action is initiated.

Data acquired during surveys and complaint/incident investigations are entered into a database, which creates queries and reports that are used to help identify trends and patterns. This information is critical in identifying systemic issues for which targeted surveys can be conducted. The data are shared with Medicaid advisory committees, industry associations, and with individual providers through the plan of correction process. The data are also used to assist with developing policies and procedures and regulations related to quality.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### **a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

##### **i. Sub-Assurances:**

***a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

##### **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:**

**HW PM1: % of participants' complaints resolved within the required time frame; Numerator: # of complaints resolved within the required time frame; Denominator: # of complaints reported**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input checked="" type="checkbox"/> Other Specify: <div>biennially</div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**Performance Measure:****HW PM2: % of incidents for which prevention strategies were developed and implemented;****Numerator: # of prevention strategies implemented Denominator: # of incidents****Data Source** (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**HW PM3: % of participants' incidents including abuse, neglect and exploitation resolved within required timeframe; Numerator: # of incidents resolved within the required timeframe; Denominator: # of incidents of abuse, neglect and exploitation reported**

**Data Source (Select one):****Critical events and incident reports**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: 
	<input checked="" type="checkbox"/> <b>Other</b> Specify:  biennially	

	<input type="checkbox"/> <b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>

	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
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**Performance Measure:**

**HW PM4: % of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe; Numerator: # of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe Denominator: # of abuse, neglect, exploitation and unexplained death incidents**

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text" value="Biennial"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>



	<input type="checkbox"/> <b>Other</b> Specify: <div data-bbox="874 203 1265 286" style="border: 1px solid black; height: 37px; width: 245px; margin-top: 5px;"></div>
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**Performance Measure:**

**HW PM5: % of enrolled waiver participants (or families / legal guardians) who know how to report abuse, neglect, exploitation and unexplained death; Numerator: # of enrolled waiver participants (or families / legal guardians) who attest to being counseled and understanding how to report abuse, neglect, exploitation and unexplained death Denominator: # of enrolled waiver participants**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Initial and annual enrollment documentation.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**HW PM 6: % of waiver participants who receive information on how to report abuse, neglect, and/or exploitation during the plan of service (POS) development process at least annually. N:# of waiver participants who receive info on how to report abuse, neglect, and/or exploitation during the POS development process at least annually. D:# of waiver participants enrolled during the annual evaluation period**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified Describe Group:</b> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuousl y and Ongoing	<input type="checkbox"/> Other Specify : <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

**HW PM7:** The % of case management agencies that received training provided by the State on identifying, addressing, and seeking to prevent abuse, neglect, and/or exploitation per waiver year (WY). N:# of case management agencies that received training provided by the State on identifying, addressing, and seeking to prevent abuse, neglect, and/or exploitation per WY. D:# of case management agencies enrolled per WY.

**Data Source (Select one): Training verification records**

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):

<b>collection/generation</b> (check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: : _____
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<div><input type="checkbox"/> <b>Other</b> Specify:</div> <div></div>	<div><input checked="" type="checkbox"/> <b>Annually</b></div>
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<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

#### 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:

**HW PM8: % of reported abuse, neglect and exploitation incidents resolved by OLTSS;**

**Numerator: # of abuse, neglect and exploitation incidents resolved Denominator: # of abuse, neglect and exploitation incidents**

**Data Source** (Select one):

**Record reviews****Critical Events and Incidents Report, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>



<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: 
	<input type="checkbox"/> <b>Other</b> Specify: 	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: 	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: 

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**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:**

**HW PM9: % of unauthorized incidents of restrictive interventions that were appropriately reported; Numerator: # of unauthorized incidents of restrictive interventions that were appropriately reported Denominator :# of unauthorized incidents of restrictive interventions**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**HW PM10: % of unapproved restrictive interventions with a prevention plan developed as a result of the incident; Numerator: # of unapproved restrictive interventions with a prevention plan developed as a result of the incident Denominator: # of unapproved restrictive interventions**

**Data Source (Select one):****Critical events and incident reports**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**HW PM11: % of restrictive interventions performed that followed State policies and procedures, as specified in the approved waiver; Numerator: # of appropriate restrictive interventions performed Denominator: # of restrictive interventions**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
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<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated 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.

#### Performance Measure:

**HW PM12: % of waiver participants who express satisfaction with the quality of services provided; Numerator: # of waiver participants who express satisfaction with the quality of services provided Denominator: # of waiver participants who completed a satisfaction survey**

**Data Source** (Select one):

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample Confidence</b>

		Interval = <div>95%/</div> <div><math>\pm</math> 5%</div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuousl y and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify : <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>

**Performance Measure:**

**HW PM13: % of waiver participants receiving preventive health care; Numerator: # of waiver participants receiving a clinical assessment Denominator: # of enrolled**



**waiver participants****Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Initial and annual enrollment documentation**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuous and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- 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.

Reportable Events data are submitted to the MDCSW Advisory Committee for review. The Committee analyzes the data and makes recommendations such as design, regulatory, and policy changes to the waivers. The OLTSS staff and case managers also works with other agencies including but not limited to, Adult Protective Services, Child Protective Services, Board of Nursing, and the Ombudsman to ensure that abuse, neglect and exploitation issues are addressed through referrals and sharing of information whenever possible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

All incidents and complaints are tracked by OLTSS staff. If an incident/complaint has not been resolved in the required timeframe of 45 days, an investigation is initiated to determine the status of the case. Findings are documented in the database or case file. Through the review of an RE, the SMA may learn that a provider is not in compliance with regulatory requirements or is providing poor quality services, and as such, will request the submission of a corrective action plan (CAP). The CAP must document how the deficiencies will be remediated, the timeframe in which this remediation will be completed, and how the provider will continuously monitor operations to ensure further deficiencies do not arise. The SMA make also takes actions against the provider, including sanctions, suspension from the waiver program, or if deficiencies are continued or egregious, disenrollment.

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
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Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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 Health and Welfare that are currently non-operational.

☒ No ☐ Yes

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

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The MDH OLTSS staff are responsible for trending, prioritizing, and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. MDH OLTSS staff are trained to ensure all system improvements of the MDCSW are implemented and continuously being addressed.

Regular reporting and communications among MDCSW providers, MDH OLTSS staff, the Utilization Control Agent, the case management agencies, and other stakeholders facilitates ongoing discovery and remediation. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include, but are not limited to, the licensing office, MDC Services Waiver providers, participants and family members and/or representatives, and the MDCSW Committee members. A plan to work on significant problem areas may result in the establishment of a specific task-group or groups, which could also involve stakeholders.

While much of these data are maintained in the state's data management and tracking system and the Maryland Medicaid Information System (MMIS2), the SMA also collects and aggregates data outside of these systems through ongoing provider audits; for example, the annual audit of case management agencies includes on-site reviews of case management agency records. The SMA utilizes a combination of reports built into the state's data management and tracking system and custom reports generated through Ad Hoc systems to extract and aggregate data. Most data analysis conducted by the SMA is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of waiver services.

~~The SMA uses the above mentioned data to direct continuous quality improvement activities. For example, in fiscal year (FY) 2019, reportable events (RE) data revealed an increase in the number of RE indicating behavioral health concerns and the complexity of those RE. As such, the SMA implemented new required training for the case management~~

Data are received, reviewed, and documented by the MDH OLTSS staff. Sources of data include but are not limited to: providers' submission of enrollment documents; reportable events; continued stay reviews; UCA reports; and complaints made by participants and/ or their family/ caregivers, and service utilization and quality by case managers. Based on the nature of this information, data are disseminated to the appropriate staff to be reviewed, prioritized, and recorded. The MDH OLTSS staff review data, noting trends and looking for anomalies that may need immediate attention. When data analysis reveals the need for system change, the MDH OLTSS staff make recommendations to the MDH OLTSS management and discuss the prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders, primarily through the forum of the MDCSW Advisory Committee, for review and recommendations. Dependent on the nature of the system/program change required, the industry, participants, family members, and the public will be notified via OLTSS transmittals, letters, memos, emails, and/ or posted on the OLTSS-MDH website. The frequency of contact is determined by the type, scope, and nature of the change.

## ii. System Improvement Activities

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:  	<input type="checkbox"/> Other Specify:  

**b. System Design Changes**



- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The efficiency of the waiver quality improvement strategy design is an ongoing process performed by the MDH LTSS staff responsible for the administration of the waiver and the implementation of program improvement and for the subsequent assessment of their effectiveness. Data will be reviewed on a quarterly basis to determine if any system changes are warranted. If a system change is required and implemented, the MDH OLTSS staff will evaluate the effectiveness of the change by analyzing the data and monitoring post system change(s). In some cases, a report compiling outcomes and lessons learned will be written. Data and lessons learned related to the change will be shared with the MDCSW Committee and other stakeholders who are engaged in formulation of program strategies.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Administering MDH OLTSS staff continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will continually flow into the waiver from many sources, such as, reportable events, waiver performance measures, provider reports, provider licensure, complaint surveys/reports, fair hearings and provider audits. If the quality improvement strategy is not working as it should, the repetition of issues and problems and unsuccessful improvement will indicate that the quality management plan must be reconfigured. To provide structure to the periodic evaluation of the quality improvement strategy, the MDH OLTSS staff will routinely involve the MDCSW Advisory Committee. A review of the effectiveness of the quality management plan will be on the MDCSW Advisory Committee meeting agenda annually.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

☒ No

☐ Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

☐ HCBS CAHPS Survey :

☐ NCI Survey :

☐ NCI AD Survey :

☐ Other (*Please provide a description of the survey tool used*):

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Single State Audit: There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.*

*The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.*

*OLTSS - The MDH OLTSS staff conduct on-site and desk audits of MDC provider as a method to ensure program integrity. Participants, claims and attendance records are reviewed to ensure program integrity. When the State reviews participant claims and attendance records as part of the on-site audit, it is checking for consistency. A provider should only request Medicaid reimbursement for dates a participant attends the center.*

*OLTSS - The MDH OLTSS staff conduct periodic surveillance and utilization reviews of MDC providers records to ensure program integrity. Surveillance and utilization reviews entail a review of a comprehensive statistical profile of provider and participant claims against provider records to ensure claims were paid appropriately.*

*The State uses a sample for surveillance and utilization reviews. The data for surveillance and utilization reports are derived from the Medicaid paid claims information and Encounter Data uploaded to the SURS database, from the MMIS-II. Through the SURS database, a comprehensive statistical profile of providers and participants who deviate from pre-defined criteria, for the purposes of analysis and review, is created to target audits or specific record reviews. Pre-defined criteria include general utilization of service, frequency, costs, diagnosis, benefit limits, and service utilization patterns.*

*The State provides written notice to providers of results of audits and record reviews. The State requires plans of correction from providers when deficiencies are identified during reviews. The State ensures the plan is being followed by the provider by conducting follow-up reviews or reviewing the plan during their next scheduled onsite audit.*

*Medical day care providers are not required to secure an independent audit of their financial statements.*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### **a. Methods for Discovery: Financial Accountability Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

##### **i. Sub-Assurances:**

##### **a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

*(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

##### **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:**

**FA PM1: % of claims that were paid in accordance with reimbursement methodology; Numerator: # of claims paid in accordance with reimbursement methodology; Denominator: # of claims reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

*If 'Other' is selected, specify:*

**MMIS**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div>95%</div> <div>+/-5</div>
<input type="checkbox"/> <b>Other Specify:</b> <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified Describe Group:</b> <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other Specify:</b> <div></div>
	<input type="checkbox"/> <b>Other Specify:</b> <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b>	<b>Frequency of data aggregation and analysis(check each that</b>
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<i>(check each that applies):</i>	<i>applies):</i>
<input checked="checked" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**FA PM2: % of paid claims with proper documentation to support the services rendered** Numerator: # of paid claims with proper documentation to support the services rendered Denominator: # of paid claims reviewed during audits

**Data Source** (Select one):Record reviews, ~~offen~~-site

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%/+-5%</div>

<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div></div>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> <i>Describe</i> <i>Group:</i> <div></div>
	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>

	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**FA PM3: % of targeted in-house utilization reviews that result in technical assistance or training for MDC provider**  
**Numerator: # of targeted in-house utilization reviews where technical assistance or training was provided**  
**Denominator: # of targeted in-house utilization reviews that resulted in the need for technical assistance or training**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**In-house record utilization reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <i>Agency</i>		
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<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample Confidence Interval</i> =
<input type="checkbox"/> <i>Other Specify:</i> <div></div>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified Describe Group:</i> <div></div>
	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <div></div>
	<input type="checkbox"/> <i>Other Specify:</i> <div></div>	

**Data Aggregation and Analysis:**

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis(check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i> <div></div>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>

	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>
--	--

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**Performance Measure:**

**FA PM4: % of targeted in-house utilization reviews that demonstrated the provider had appropriate internal fiscal integrity controls** Numerator: # of targeted in-house utilization reviews that demonstrated the provider had appropriate internal fiscal integrity controls Denominator: # of targeted in-house utilization reviews

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**FA PM5: % of providers<sub>2</sub> billing dates of service within the participant's authorized Service Plan;**  
**Numerator: # of audited providers with billing dates of service within the participant's authorized Service Plan; Denominator: # of audited providers**

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%/+5%</div>

<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> <i>Describe</i> <i>Group:</i>
--	---	--

<input type="text"/>		<input type="text"/>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>
	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>

**Performance Measure:****FA PM6: % of targeted in-house utilization reviews resulting in recoupment of waiver funds****Numerator: # of targeted in-house utilization reviews resulting in recoupment. Denominator: # of targeted in-house utilization reviews that resulted in a recovery request.****Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b> (check
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<b>data collection/generation</b> (check each that applies):	<b>collection/generation</b> (check each that applies):	<b>each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence Interval</b> =
<input type="checkbox"/> <b>Other Specify:</b> <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified Describe Group:</b> <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other Specify:</b> <div></div>
	<input type="checkbox"/> <b>Other Specify:</b> <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<div><input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div></div></div>	<div><input checked="" type="checkbox"/> <i>Annually</i></div>
--	--



<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

### **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:**

**FA PM7: % of claims paid according to the State's rate for services.- ~~per diem rate for MDC~~**

**Numerator: # of claims paid according to the State's rate for services.-~~per diem rate for MDC~~**

**Denominator: # of paid claims reviewed.~~paid for MDC~~**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS-II ADHOC report**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample Confidence Interval</i> <div></div>
<input type="checkbox"/> <i>Other</i>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i>

Specify: <div></div>		Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>

- 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.

The Surveillance and Utilization Review Subsystem (SURS) is a federally required component of the Medicaid Management Information System (MMIS). Its purpose is to provide comprehensive profiles of the utilization of services by providers and recipients of the Medicaid Program. These reports are used to assist in the detection of Program fraud and abuse, monitor quality of service, and provide for the development of Program policy.

The data for SURS reports are derived from the Medicaid claims information and encounter data to produce a comprehensive statistical profile on providers who deviated from pre-defined criteria for the purposes of analysis and [review](#).

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The MDCSW has a set per diem rate for MDC services and incremental rate for case management. Participants must attend the center for four (4) or more hours per day. When the State finds that a provider has billed for a day of service for which the participant attended the center less than the required number of hours, funds will be recovered. When appropriate, a corrective action plan is required within 15 business days. When fraud or abuse is suspected, the case is referred to the Office of the Inspector General for review.

Case management activities are captured in LTSSMaryland and reimbursed in 15-minute increments for administrative or ongoing case management procedures.

When a provider is found to have billed for dates of services beyond the prescribed number of days in the participant's service plan, funds will be recovered for all service dates that were not in accordance with the participant's service plan. A corrective action plan will be required within 15 business days. When fraud or abuse is suspected, the case is referred to the Office of the Inspector General for their review.

In the event that a system edit in the Maryland Medicaid Information System (MMIS2) ceases to function SMA staff will consult with the appropriate office within the SMA to determine the nature of the problem with the edit, the steps for remediation, and the impacted claims. If the problem cannot be immediately remediated SMA staff will submit a customer service request for necessary programming to be completed. The SMA will also rectify any over or underpayment to providers through the claims adjustment process.

**ii. Remediation Data Aggregation****Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**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 Financial Accountability that are currently non-operational.

☒ No ☐ Yes

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing*

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

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## ***Appendix I: Financial Accountability***

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### ***I-2: Rates, Billing and Claims (1 of 3)***

- a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Payment to case management agencies is reimbursed based on the number of units of service provided. Case management activities are billable based on the activity and the number of minutes it took to complete the action. Case management billable units are 15-minute increments. Rates are subject to the State's budget and are published via rate transmittal and in accordance with COMAR 10.09.07. Case management rate is based on comparable home and community-based programs where case management is a waiver service.

Payments to providers of the medical day care service are reimbursed on a per diem basis. The per diem rate is effective for one fiscal year, unless otherwise specified. The established medical day care provider rate is subject to the limitations of the State's budget. Rate changes and methodologies are approved annually through the State Budget process and presented to Medicaid advisory boards and the industry to solicit comments prior to the rates being published in the Maryland Register. Once published, there is a 30-day public comment period. Each fiscal year, notifications of rate changes are communicated via Medicaid transmittal, to all participating providers. Medicaid transmittals are posted on the MDH website for public view.

Reimbursements to MDC providers are paid on a per diem basis. Parameters are set in the MMIS II that disallows payment for services rendered to participants who are not enrolled in the Waiver. Upon adjudication, MMIS II validates each claim using edit parameters to verify service eligibility. To further ensure financial accountability, audits of claims reimbursed are conducted by the OLTSS and OIG.

Each year, subject to the limitations of the State's budget, the per diem rate shall be adjusted by the percentage of the annual increase in the previous July Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from U.S. Department of Labor, Bureau of Labor Statistics. Any increase approved for the medical day care service rate may not be greater than 4 percent (plus, not minus).

To determine per diem rate increases, the two data sources used are statistics from the U.S. Department of Labor, Bureau of Labor Statistics and Medical Assistance Rate Transmittals. The inputs used from the U.S. Department of Labor, Bureau of Labor Statistics include the two previous July indexes. The percentage change between the two July indexes is multiplied by the current rate found in the Medical Assistance Rate Transmittals to produce an amount to increase or decrease the current rate. The sum of the amount is added or subtracted to the current rate, to establish the new rate.

When the medical day care rate is subject to the limitations of the State's budget, the State Medicaid Agency and the Department of Budget and Management base Program allocations on State revenue collected and Program priorities. The State reviews and rebases rates annually, using the CPI. The State Medicaid Agency is responsible for rate determination and oversight. The State Medicaid agency calculates the CPI and based on the limitations of the budget and Program priorities, determines if the CPI increase will be approved or denied. A cost-based analysis of the bundled services offered is not conducted.

Rate changes and methodologies are approved through the State Budget process and presented to Medicaid Advisory boards and the industry to solicit comments prior to the rates being published in the Maryland Register. Once published, there is a 30-day public comment period. Each fiscal year, notifications of rate changes are communicated via Medicaid transmittal, to all participating providers. Medicaid transmittals are posted on the OLTSS website for public view.

#### State's Rate Model Detail:

Currently, there are 117 providers with a licensed capacity 10,022 serving approximately 6,000 program participants in 24 jurisdictions. Overall, Maryland's rates appear analogous to the service provided by other states and the pool of providers available are sufficient, based on the number of participants being served and the licensed capacity of 117 providers.

#### **\*\*Historical Data\*\***

The Medical Day Care Service rate methodology, referenced in COMAR 10.09.07, was first established January 1, 1980. The initial maximum per diem rate of \$24.98 was 75% of the Intermediate Care Facility Services' maximum per diem rate. Each provider was assigned an interim per diem rate through a cost settlement process. To determine a facility's direct and indirect costs, the following costs were reported by a facility:



Personnel Transportation Supplies and equipment Food Administrative overhead  
Medical and rehabilitative services

The methodology of establishing a Medical Day Care Service maximum per diem rate, based on 75% of the Intermediate Care Facility Services' maximum per diem rate, in conjunction with a facility cost settlement based interim rate, was utilized January 1, 1980 through June 30, 1983.

Effective July 1, 1983, the program continued to utilize a cost settlement process. However, the Medical Day Care Service maximum per diem rate was no longer based on 75% of the Intermediate Care Facility Services' maximum per diem rate. The base maximum per diem rate was determined by adjusting 80% of the change in the March – Baltimore Metropolitan Consumer Price Index-W for Urban Wage Earners and Clerical Workers (CPI-W). Medical day care facilities' interim per diem rates continued to be established through a cost settlement process that included aforementioned direct and indirect costs. This methodology was utilized through June 30, 1991.

Effective July, 1, 1991, the Medical Day Care Service per diem rate was no longer subject to cost settlement. Additionally, the maximum and interim per diem rates were discontinued. The Medical Day Care Service rate was determined by adjusting the per diem rate for fiscal year 1991 by the annual percentage increase in the U.S. Department of Labor March Consumer Price Index for All Urban Consumers (CPI-U), medical care services component, Baltimore.

When the Medical Day Care Services Waiver was established on July 1, 2008, the program began adjusting the service rate by utilizing the percentage of the annual increase in the March Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics, subject to the limitations of the State budget. The program continued to use this methodology through June 30, 2016.

Effective July 1, 2016, the Medical Day Care Service modified the indexing of rates to ensure the amount of the applicable index would be known during the development of the State budget. The program discontinued using the percentage change of the annual March CPI-U and began utilizing the percentage change in the July CPI-U.

Currently, Maryland has chosen to use the Washington-Baltimore Consumer Price Index for All Urban Consumers (CPI), medical care component to ensure that rates remain adequate. The Washington-Baltimore CPI, medical care component accounts for inflation and reflects the average price change over time for a constant quality, constant quantity market basket of goods and services. The medical care cost expenditure categories include:

- Professional services;
- Hospital and related services;
- Health insurance premiums;
- Drugs; and
- Medical equipment and supplies.

The cost expenditure categories use to calculate the CPI, medical care component is sufficient for ensuring the medical day care service rate remains adequate to cover the cost increases experienced by economically operated providers.

In August 2014, Maryland conducted a comparison rate study of seven states offering the medical day care service. The study findings support the adequacy of Maryland's rate. The average daily rate for the medical day care service in the comparison states was \$66.23/day and Maryland's rate was \$73.58/day. Of the seven comparison states, three states had rates lower than Maryland—North Carolina, Idaho and Georgia—and four were above Maryland—Maine, Louisiana, Florida, and Arkansas. The lowest rate was North Carolina's, which was \$38.53/day and the highest rate was Arkansas', which was \$81.28/day. Maryland's current rate of \$75.99 for the medical day care service appears to be comparable to similar service rates in other states offering the service as a benefit.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

AMDC Services Waiver providers bill the State directly and claims are processed by the Program's MMIS while MDC CMA claims created in LTSSMaryland and adjudicated in MMIS. are processed through LTSSMaryland.

### ***Appendix I: Financial Accountability***

#### **I-2: Rates, Billing and Claims (2 of 3)**

##### **c. Certifying Public Expenditures (select one):**

- ☒ No. state or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- ☐ Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

### ***Appendix I: Financial Accountability***

#### **I-2: Rates, Billing and Claims (3 of 3)**

- d. Billing Validation Process.** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS) or LTSSMaryland. MMIS edits each claim to validate the participant's waiver eligibility on the date of service. Requests are made for federal financial participation based on claims processed through the MMIS. Pre and post payment review methodologies will be employed to ensure that payment is made only for services that are included in the participant's approved service plan and received by the participant.

The State recoups payments for inappropriate billings via post-payment reviews. Recoveries for inappropriate claims are processed through MMIS where both the state and federal share are recognized. A recovery made in the aforementioned manner is netted against the weekly draw of federal match, in the same week recovered. The FFP for the inappropriate claim is returned in the weekly draw process as a netted transaction.

- e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

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**Appendix I: Financial Accountability I-3: Payment (1 of 7)**

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**a. Method of payments -- MMIS (select one):**

- ☒ Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).  
☐ Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

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**Appendix I: Financial Accountability I-3: Payment (2 of 7)**

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- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☒ The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.  
☐ The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program. The  
☐ Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

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**Appendix I: Financial Accountability I-3: Payment (3 of 7)**

- c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ☒ No. The state does not make supplemental or enhanced payments for waiver services.
- ☐ Yes. The state makes supplemental or enhanced payments for waiver services.

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

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**Appendix I: Financial Accountability I-3: Payment (4 of 7)**

- d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☐ No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- ☒ Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Both county-owned MDC centers and MDC centers operated by local health departments provide the same MDC services as privately owned MDCs. The following is a list of such MDC providers: Adult Day Care of Calvert County, Caroline County Medical ADCC (LHD), Kent County MADCC LHD), and Worcester AMD Services.



## I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ☒ The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

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**Appendix I: Financial Accountability I-3: Payment (6 of 7)**
**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- ☒ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

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**Appendix I: Financial Accountability I-3: Payment (7 of 7)**
**g. Additional Payment Arrangements****i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

- ☒ No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- ☐ Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System. Select one:**

- ☒ No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.
- ☐ Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.**

- ☒ The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- ☐ The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.



In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans

that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

### Appendix I: Financial Accountability

#### I-4: Non-Federal Matching Funds (1 of 3)

**a.** State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☒ Appropriation of State Tax Revenues to the State Medicaid Agency
- ☐ Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

- ☐ Other State Level Source(s) of Funds.

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

### Appendix I: Financial Accountability

#### I-4: Non-Federal Matching Funds (2 of 3)

**b.** Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- ☒ Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
- ☐ Applicable

Check each that applies:

- ☐ Appropriation of Local Government Revenues.

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or*

*Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

- ☐ Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

### Appendix I: Financial Accountability

#### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

☒ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs*** ☐ The following source(s) are used

Check each that applies:

☐ Health care-related taxes or fees ☐ Provider-related donations ☐ Federal funds

☐ *For each source of funds indicated above, describe the source of the funds in detail:*

### Appendix I: Financial Accountability

#### I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings. Select one:

☒ No services under this waiver are furnished in residential settings other than the private residence of the individual.  
☐ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

### Appendix I: Financial Accountability

## I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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**Appendix I: Financial Accountability**


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 I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- ☒ No. The state does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ Nominal deductible Coinsurance
- ☐ Co-Payment Other charge
- ☐ Specify:

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**Appendix I: Financial Accountability**


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 I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

| a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

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Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- ☐ Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	17882.64	21028.00	38910.64	72994.00	9783.00	82777.00	43866.36
2	18237.52	22541.00	40778.52	74644.00	10062.00	84706.00	43927.48



Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
3	18600.16	24162.00	42762.16	76332.00	10350.00	86682.00	43919.84
4	<u>25742.8</u> <u>439,034.</u> <u>4718970.</u> <u>38</u>	<u>27375.10</u> <u>25899.00</u>	<u>53117.9</u> <u>466,409.</u> <u>5744869.</u> <u>38</u>	<u>94,240.76</u> <u>78058.00</u>	<u>11705.95</u> <u>10646.00</u>	<u>105946.71</u> <u>88704.00</u>	<u>52828.77</u> <u>39,537.14</u> <u>43834.62</u>
5	<u>28028.3</u> <u>142,398.</u> <u>2319249.</u> <u>27</u>	<u>29829.66</u> <u>27762.00</u>	<u>57857.9</u> <u>772,227.</u> <u>8947011.</u> <u>27</u>	<u>97322.43</u> <u>79823.00</u>	<u>12088.74</u> <u>10951.00</u>	<u>109411.17</u> <u>90774.00</u>	<u>51553.2037,183</u> <u>2843762.73</u>

#### Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (1 of 9)

- a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		
		Nursing Facility		
Year 1	7720		7720	
Year 2	7913		7913	
Year 3	8111		8111	
Year 4	<u>83145483</u>		<u>83145483</u>	
Year 5	<u>85215633</u>		<u>85215633</u>	

#### Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimated ALOS per MDC Waiver participant during WY's 1 to 5 is 311.29 days. This estimate will remain constant during WYs 1 to 5. This figure was estimated using the actual (FY 2015 to FY 2019) average annual MDC Waiver participant ALOS (total waiver days/number of service users) data. Each annual average ALOS was then summed and averaged to obtain the overall ALOS (310.65). Hilltop also calculated a trend factor (0.0021 percent) using the annual percent change in the annual ALOS from FY 2015 to FY 2019. This trend factor was applied to the overall ALOS to obtain the FY 2020 ALOS (311.29) estimate.

#### Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.
- i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Based on an analysis of current waiver data the average units of service per user is 201.80. It is projected that the average units of service per user will remain relatively constant over the next five years of the waiver renewal.

Factor D estimates are based on the actual FY 2017 to FY 2019 service utilization and expenditures for MDC Waiver participants. Using the 372 Report data, Hilltop calculated an annual unit cost trend factor and a utilization trend factor for the one waiver service. The annual unit cost trend factor is the total waiver expenditures divided by the total number of unique service users. The annual utilization trend factor is the total number of service units divided by the total number of unique service users. We averaged the FY 2018 and FY 2019 unit cost trends to provide the overall unit cost trend, and we did the same for the utilization trend. We then multiplied the averaged trend factors to obtain the final combined unit cost/utilization trend factor. We applied this factor to the FY 2019 (base year) waiver service to estimate Factor D for WYs 1 to 5.

For the updated Factor D, estimates for WY4/FY26 and WY5/FY27 are based on establishing FY 2025 (avg cost per participant for medical day care waiver services only: \$24,356.36) as the base year using actual utilization from FY 2023 and FY 2024 and applying a service utilization and unit cost trend. For medical day care services, Hilltop applied linear exponential smoothing analyses to project the annualized trend factors for waiver utilization for WY4/FY26 and WY5/FY27.

Additionally, an annualized 3% trend for waiver unit costs was estimated. These trends were then used to project utilization and unit costs in the renewal years for medical day care waiver services. For the new to be implemented case management service, utilization was assumed at 12 units per participant per year with a unit cost of \$23.56 in WY4/FY 26. Case management utilization for WY4/FY26 was adjusted for the projected February 2026 implementation date.

- ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was estimated using the annual CMS 372 Report state plan utilization and expenditures data for the same population. As above, we calculated the annual cost trend factors and utilization trend factors.

We multiplied the average of the annual cost trends and the utilization trends to obtain the combined unit cost/utilization trend factor used to estimate the Factor D' estimates. Estimates of Factor D' do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual-eligible beneficiaries.

To estimate individual service utilization, Hilltop calculated the percentage of unduplicated service users (number of unduplicated service users/total waiver participants) per for the MDC service, per year using actual FY 2015 to FY 2019 service utilization data. We applied the maximum percentage of unduplicated users for each service across the five-year period to the estimated annual number of unduplicated WY participants to determine the unduplicated number of participants for the MDC service for that waiver year. To estimate waiver costs and units of service, we used actual FY 2019 user counts, total units, units per person, cost per unit, and total costs for each service. In WYs 1 to 5, units per person and cost per unit were estimated by multiplying the number of service users established above by the utilization trend and by the unit cost trend, respectively. We then multiplied the total number of units for that service by the cost per unit to obtain the WY cost for each service. Service totals were summed and divided by the estimated number of waiver participants to obtain D. This D should be the same or very similar to the D obtained above.

For the updated, Factor D' estimates for WY4/FY26 and WY5/FY27, Hilltop used the FY 2025 D' cost (\$26,080.84) as the base year and applied an average of the past 12-month Consumer Price Index (CPI) from July 2024 to June 2025, which is 3.27%, as the trend factor to project D' costs in the renewal years.

- iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G and G' were estimated using Medicaid expenditures for persons with at least one nursing facility claim in FY 2017, FY 2018, or FY 2019. The process for obtaining the estimates used the same unit cost trend and utilization trend methodology. However, for Factor G' the annual increase factor was the Medical Care Consumer Price Index (CPI).

For the updated Factor G, NF costs were gathered from all Maryland Medicaid NFs for individuals who have been in care for over 100 days. Costs were categorized as institutional and all other Medicaid costs. Hilltop used the FY 2025 average NF costs (\$91,256.67) as the base year for the Factor G estimates and compounded this by an annual increase of 3.27%, based on the past twelve-month CPI for Medical Care Services.

- iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G and G' were estimated using Medicaid expenditures for persons with at least one nursing facility claim in FY 2017, FY 2018, or FY 2019. The process for obtaining the estimates used the same unit cost trend and utilization trend methodology. However, for Factor G' the annual increase factor was the Medical Care Consumer Price Index (CPI).

For the updated Factor G', estimates utilized the same methodology and Factor G. Hilltop used the FY 2025 average all other Medicaid costs for individuals who had been in NF care for over 100 days (\$11,335.29) as the base year for the Factor G' estimates and compounded this by the same annual increase of 3.27%, based on the past twelve-month CPI for Medical Care Services.

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#### ***Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (4 of 9)***

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.



Average Length of Stay on the Waiver: 311

***Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (7 of 9)***

- d. Estimate of Factor D.
  - i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.

[illegible]

**Appendix J: Cost Neutrality Demonstration J-2: Derivation of Estimates (9 of 9)**

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## d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

[illegible]