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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §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 waivers 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

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

~~Maryland's application for the renewal of the Waiver for Adults with Brain Injury will include the following changes:~~

~~Update to the definition of Individual Support Services (ISS) to match COMAR and allow for remote supports.~~
This waiver amendment includes:
1. The transition to for fee-for-service billing using the State's data management system.
2. The transition to Electronic Visit Verification (EVV) for billing of Individual Support Services (ISS).

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

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 §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*):

Brain Injury renewal waiver

C. Type of Request: 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**

Original Base Waiver Number: MD.40198
Waiver Number:MD.40198.R04.00
Draft ID: MD.023.04.00

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

Regular Waiver

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

07/01/23~~21~~

Approved Effective Date: 07/01/21

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:

Rehabilitative/chronic/specialty for brain injury programs

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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 §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §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 §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity 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

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.

Maryland's Home and Community-Based Services Waiver for Adults with Brain Injury was implemented July 1, 2003. The operating state agency (OSA) is the Behavioral Health Administration (BHA), with oversight from the State Medicaid Agency (SMA) by the Office of Long Term Services and Supports (OLTSS)

The program was initially designed as a resource for Maryland residents with brain injury who could not be served in traditional long-term care settings within the state, primarily due to the severity of their neurobehavioral deficits. Events that precipitated the creation of this program included the out-of-state placement of several individuals with brain injury accompanied by complex needs, and an increasing number of individuals who remained in state psychiatric hospitals due to the lack of appropriate care alternatives within the State of Maryland. The target population was quite specific, and the program was originally intended to be small: 10 slots were approved for the first year, 20 slots for the second year, and 30 slots in each year thereafter.

Technical eligibility is based on the type of injury, age at injury, and the location where the applicant is residing. At the start of the program, the technical eligibility criterion related to the treatment setting at the time of referral limited participation in this waiver to individuals in state psychiatric hospitals, in out-of-state placements, or in state-owned and operated nursing facilities. At the time of the first renewal, technical eligibility was expanded to individuals in private chronic hospitals that hold accreditation by the Commission on the Accreditation of Rehabilitation Facilities (CARF) for brain injury rehabilitation. This change in eligibility resulted in several outcomes: (1) referrals to the waiver program increased; (2) the needs of the participants transitioning from the chronic hospitals differed from the needs of the early participants, requiring BHA and OLTSS to re-examine the design and implementation of waiver services; and (3) enrollment in the Brain Injury Waiver became a diversion from traditional long term care options such as nursing facilities, and has resulted in positive outcomes for waiver participants. At the time of the second renewal, another technical eligibility criterion changed: the qualifying age of onset of the brain injury was decreased from age 21 to age 17. Another significant change to technical eligibility occurred in January 2014, when the definition of brain injury was expanded from only an injury resulting from outside trauma, to include any acquired brain injury resulting in the level of service need provided by the waiver.

There are five services available through the Brain Injury Waiver: residential habilitation, day habilitation, supported employment, medical day care, and individual support services. Individuals are offered administrative case management, to assist them with developing the plan of service. Providers of brain injury services are required to be licensed by the Developmental Disabilities Administration, and have expertise in the provision of services to individuals with brain injury. There is no enrollment cap for eligible individuals who meet criteria to move from an institution to the community through a state-level "money follows the individual" program, or qualify for the federal Money Follows the Person (MFP) program.

3. Components of the Waiver Request

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

A. Comparability. The state requests a waiver of the requirements contained in §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 §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §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

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 in-patients of a hospital, nursing facility or ICF/IID.

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

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

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

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

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

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

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

The Brain Injury Waiver Advisory Committee meets quarterly to review BI waiver activities, data, and outcomes and provides input to BHA and OLTSS regarding program design. This committee is a standing subcommittee of the Maryland TBI Advisory Board, which is legislatively mandated and reports annually to the Governor and the Secretary of the Department of Health.

Recommendations of the BI Waiver Advisory Committee that require changes to COMAR regulations or to the waiver application are typically proposed first to the Maryland TBI Advisory Board, which then in turn makes formal recommendations in its annual report.

~~Waiver participants are offered an opportunity to participate in an annual survey that is conducted by adult peers who have sustained a brain injury. The selected survey tool is the Participant Experience Survey. Results of this survey are aggregated and trends are shared with the BI Waiver Advisory Committee and with waiver providers.~~

~~When new or amended regulations or waiver amendments/renewals are proposed by MDH, a notice is required to be published in the Maryland Register. Regulations may not be promulgated until an opportunity for public comment is provided, including a response from MDH to all public comments received.~~ Request for public input for the BI waiver renewal was posted in the Maryland Register (Issue Date: January 29, 2021, Volume 48, Issue 3) which is available electronically and via hard copies statewide at the local health departments and at public libraries. An electronic version of the renewal application was posted to the Department's website on April [X], 2023 .

Maryland's Tribal Government, the Urban Indian Organization (UIO) was consulted and provided notice via email on April [X], 2023 . The UIO responded via email on April [X], 2023 stating [xx].

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)

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

Last Name: Jones

First Name: Alisa

Title: Chief, Division of Community Long Term Care

Agency: Department of Health

Address: 201 W. Preston Street

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-3014 **Ext:** ☐ **TTY**

Fax: (410) 333-5362

E-mail: alisa.jones@maryland.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: O'Dea

First Name: Stefani

Title: Director, Office of Older Adults and Long Term Services and Supports

Agency: Behavioral Health Administration

Address: Spring Grove Hospital/ Mitchell Building

Address 2: 55 Wade Avenue

City: Catonsville

State: **Maryland**

Zip: 21228

Phone: (410) 402-8476 **Ext:** ☐ **TTY**

Fax: (410) 402-8304

E-mail: stefani.odea@maryland.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §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: ~~Carrie Goodman~~

State Medicaid Director or Designee

Submission Date: ~~Jun 11, 2021~~

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

Last Name: Hutchinson

First Name: Marlana

Title: Director, Office of Long Term Services and Supports

Agency: Department of Health

Address: 201 West Preston Street

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-1443 **Ext:** ☐ **TTY**

Fax: (410) 767-5212

E-mail: marlana.hutchinson@maryland.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **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:

Not applicable.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

CMS granted Maryland initial approval of its Statewide Transition Plan (STP) on April 17, 2017.

The current plan is posted for public review and comment on the Department website at:
https://mmcp.health.maryland.gov/waiverprograms/pages/Community-Settings-Final-Rule.aspx

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:

(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.

Behavioral Health Administration

(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:

MDH is the single State Medicaid Agency SMA) authorized to administer Maryland's Medical Assistance Program. MDH's OLTSS oversees the BI Waiver. In this capacity, OLTSS oversees the performance of BHA, Operating State Agency (OSA) for the waiver. The functions that are delegated to the OSA are:

1. Waiver enrollment managed against approved limits
2. Waiver expenditures managed against approved levels
3. Review of participant service plans
4. Prior authorization of waiver services
5. Utilization management
6. Qualified provider enrollment
7. Rules, policies, procedures and information development governing the waiver program
8. Quality assurance and quality improvement activities

The Brain Injury Waiver Program application, enrollment and eligibility process are completed through the State's data management system.

OLTSS is responsible for monitoring BHA through: 1) Quality Management Reports that outline, in detail, quality assurance activities and each entity responsible for that activity 2) quarterly inter-agency waiver coordination meetings between OLTSS and BHA to discuss issues, policy, and remediation.

As previously stated, OLTSS and BHA have developed and implemented a Quality Management Plan, which is based upon assuring waiver participant health and safety through appropriate level of care determinations; monitoring and approving plans of care; enrolling qualified providers; monitoring provider performance and providing training; implementing a system for reporting critical events and complaints; providing administrative oversight and financial accountability.

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.:*

Medicaid utilizes the services of a contracted Utilization Control Agent.

For the Medicaid Waiver for Adults with Brain Injury, the UCA conducts initial and annual determinations of Level of Care (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:

Maryland's Behavioral Health Administration (BHA), the OSA for the BI Waiver, contracts with the Brain Injury Association of Maryland (BIA-MD) to provide enhanced transitional case management services to MFP participants.

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:

There are ~~three~~ two non-state entities that perform administrative functions for the BI Waiver. These are the BIA-MD that contracts for enhanced transitional case management and~~,~~ Medicaid's Utilization Control Agent (UCA~~), and an Administrative Services Organization (ASO)~~. The BHA has responsibility for assessment of the performance of the BIA-MD. OLTSS is responsible for assessment of the performance of the UCA ~~and the ASO~~.

Appendix A: Waiver Administration and Operation

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 BHA Office of Local Planning and Management is responsible for the oversight of the contract between BHA and the BIA-MD.

~~Administrative Services Organization~~
~~The ASO is selected and contracted by BHA through a state procurement process to manage the public mental health system. Services provided include utilization management, network management, access to care, claims payment, federal fund attainment, evaluation, data collection, and special projects. After BHA authorizes services, the ASO pays claims for BI Waiver services to licensed BI providers where there are no errors or reasons for the claim to be denied. The ASO submits claims to MMIS for federal claiming. BHAs Deputy Director of Community Programs and Managed Care is the contract monitor for the ASO contract. BHA conducts an annual review of the ASO to assure the ASO is providing services as required in its contract with BHA. In addition, representatives of BHA leadership meet with the ASO bi-monthly to review contract compliance. Monthly meetings with Maryland Medicaid, BHA and the ASO are convened to identify issues to be addressed and to review policies and procedures. The ASO's management of the waiver is for claims payment and federal fund collections.~~

Utilization Control Agent
OLTSS contracts with a UCA to perform level of care determinations. On a monthly basis, staff performs budget reconciliation for the UCA and review statistical reports to evaluate performance. Additionally, staff reviews the appropriateness of level of care determinations ongoing.

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	☒	☐	☐
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☐	☐
Prior authorization of waiver services	☒	☐	☐
~~Utilization management~~	☒	☒	☐
Qualified provider enrollment	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☐	☐

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Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: 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: Number and percent of unduplicated participants for whom an Authorization to Participate (ATP) to SMA that remains less than or equal to the number of slots available. N = # of unduplicated participants for whom ATPs are issued D = # of participants in approved waiver slots

Data Source (Select one):
Meeting minutes
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA.PM2: Number and percent of policies and procedures developed by OSA that were reviewed and approved by the SMA prior to implementation. N: # of policies & procedures developed by the OSA that were reviewed and approved by the SMA prior to implementation D: # of policies & procedures developed

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

PM1: The OSA reviews the number of approved participants and the number of available slots on a quarterly basis to the SMA. The data will be reviewed during quarterly inter-agency coordination meetings.

PM2: Any new policy or procedure change will be discussed at quarterly inter-agency meetings between the OSA and the SMA. If policies and procedures are being implemented and changed prior to the SMA's approval a letter will be sent from the SMA to the OSA and a CAP will be requested.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 SubGroup	Minimum Age			Maximum Age			Maximum Age	
						Maximum Age Limit			No Maximum Age Limit	
☐ Aged or Disabled, or Both - General										
	☐	Aged							☐	
	☐	Disabled (Physical)								
	☐	Disabled (Other)								
☒ Aged or Disabled, or Both - Specific Recognized Subgroups										
	☒	Brain Injury		22					☒	
	☐	HIV/AIDS							☐	
	☐	Medically Fragile							☐	
	☐	Technology Dependent							☐	
☐ Intellectual Disability or Developmental Disability, or Both										
	☐	Autism							☐	
	☐	Developmental Disability							☐	
	☐	Intellectual Disability							☐	
☐ Mental Illness										
	☐	Mental Illness							☐	
	☐	Serious Emotional Disturbance								

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

Individuals aged 22 through 64, who at the time of qualifying injury and admission to the waiver but once admitted, may remain past the age of 64 as long as the other waiver eligibility criteria are met. Waiver services are limited to individuals diagnosed with brain injury that was sustained after age 17. Participants must be discharged into waiver services from a stay in a State psychiatric hospital that is determined to be inappropriate, including individuals funded in community placements by the Departments Behavioral Health Administration with all state funds, or from a Medicaid placement in an out-of-state facility or from a nursing facility owned and operated by the state or from a Maryland licensed Special Hospital for Chronic Disease with CARF Accreditation for inpatient brain injury rehabilitation.

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:

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)

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

The Department has implemented standardized assessment tools to assist with determining eligibility, service needs, and service planning. Prior to participant enrollment, the waiver application process includes completion of the standardized assessments. The Mayo Portland Adaptability Inventory (MPAI4), which generates a score, and the Agitated Behavior Scale (ABS) as well as a Medical Eligibility Review Form (MDH3871) are completed prior to enrollment and uploaded into the State's data management system. The score of the MPAI, results of the ABS, and the medical and rehabilitation needs captured on the MDH 3871 are reviewed by the transitional case manager and the OSA to determine whether the individual's needs can be safely met in the community and whether plan of service needs are within cost neutrality limits. The waiver application process continues for individuals whose needs can be met through the program. For those individuals whose needs are not cost neutral and/or cannot be safely met through the program, a denial is submitted through the State's data management system. The Eligibility Determination Division (EDD) generates a denial letter, including appeal rights, to the applicant.

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:

Individuals with brain injury often experience periods of behavioral or psychiatric instability that require a change in the plan of service. Typically in these situations, the level of day habilitation or residential habilitation service is increased temporarily (typically 30-90 days) as a new behavioral intervention strategy and/or medications are being implemented. This short term intervention often diverts costly hospitalization. This service enhancement is still within cost neutrality limits. If an individual requires a higher level of service long term, a higher level of care is requested, increasing the overall cost neutrality limit. Cost-neutrality is typically at risk only if the higher level of care is not approved. Alternative services have to be considered at this time or in some cases, a secure setting may be required and the individual must be dis-enrolled.

The other area of need that threatens cost neutrality for this population is skilled nursing needs. Enrolled providers operate under the Nurse Practice Act (COMAR 10.27). They employ or contract with registered nurses who are required to provide comprehensive nursing assessments and delegate nursing tasks such as medication administration, gastric tube feedings, and some wound care. Participants' medical conditions must be chronic, stable, uncomplicated and predictable in order to be managed through nurse delegation. Therefore, if a waiver participant's medical needs change and become unpredictable, complicated or unstable and the nursing needs are not delegable, they must be dis-enrolled from the program and receive services in a skilled nursing facility. Once the participant's medical condition is stable, they are re-enrolled in the waiver program.

In some instances acute hospitalization or State Plan home health services may be appropriate to stabilize an individual's medical condition. An individual remains in the waiver during acute hospitalizations and when State Plan home health services are required.

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	135
Year 2	145
Year 3	155
Year 4	165
Year 5	175

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	
Year 2	
Year 3	
Year 4	
Year 5	

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:

Entry into the waiver is based upon the date of the applicant meeting all of the criteria for participation in the program: technical eligibility, medical eligibility and financial eligibility.

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)*:

- (●) **§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)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

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

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

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

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

Specify:

Individuals who meet the income and resource requirements of the cash assistance programs (42CFR§435.210).
Individuals receiving aid to families with dependent children. (§435.110)
Pregnant women (§435.116).
Infants and children under age 19 (§435.118).

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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

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

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

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.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's

income:

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**
○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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 complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- (●) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:
- ( ) **The following dollar amount:**

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

  Specify formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Appendix B: Participant Access and Eligibility

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 complete this section and therefore this section

is not visible.

Appendix B: Participant Access and Eligibility

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

The state requires the use of at least one waiver service in a 12 month period.

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

The Department's Utilization Control Agent (UCA).

- ○ **Other**

Specify:

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

The State Medicaid Agency contracts with a UCA that is a Quality Improvement Organization to determine a waiver applicant's LOC.

Registered nurses (RN), hired by the UCA, perform the initial evaluation to certify nursing facility LOC. Each RN must meet current licensing requirements for nurses as set forth by the Board of Nursing.

The UCA and OLTSS employ a physician to assist in the initial evaluation process by determining the LOC when there are unusually complex or contested decisions by the nurse reviewers. Each physician must meet current licensing requirements for physicians as set forth by the Maryland State Board of Physicians.

All LOC determinations are subject to review and approval by the Medicaid agency.

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 LOC criteria for waiver services is the same criteria used for institutional services. The UCA performs evaluations utilizing the standardized assessments: the Mayo Portland Adaptability Inventory (MPAI-4)and the Agitated Behavior Scale (ABS).

The MPAI-4 assesses disability after a brain injury, using three scored subscales: Ability Index, Adjustment Index and Participation Index. The subscales address activities of daily living, instrumental activities of daily living, behavioral issues and cognitive ability.

The ABS measures behavioral aspects of agitation during the recovery phase after a brain injury. The assessment is comprised of 14 scored items that address disinhibition, aggression and lability.

Both assessments are uploaded into the State’s data management system and can be accessed by the UCA as supporting documentation. The contractor reviews the Medical Eligibility Review Form (MDH 3871) as well as the results of the standardized assessments, to assess each applicant for nursing facility or chronic hospital level of care.

service coordinators are responsible for coordinating the medical eligibility determination during the child's initial and annual redetermination waiver application. In order to meet the eligibility requirement an intermediate care facility for individuals with intellectual disabilities (ICF/IID) LOC is required. The level of care evaluation instrument is used for determining LOC

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The Utilization Control Agent (UCA) reviews information on the State's Medical Eligibility Review form, called the MDH 3871, to evaluate the participant's level of care during the application process and during the annual re-determination process. The 3871 and supporting medical documentation, which includes the MPAI and ABS, and may include other medical reports, is uploaded to the State's data management system by the waiver case manager. The information is reviewed by the UCA. The LOC decision and effective date are entered in the State's data management system once a decision is made.

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 Utilization Control Agent (UCA) reviews information on the State's Medical Eligibility Review form, called the MDH 3871, to re-evaluate the participant's level of care during the annual re-determination process. The 3871 and supporting medical documentation, which includes the MPAI and ABS, and may include other medical reports, is uploaded to the State's data management system by the waiver case manager. The information is reviewed by the UCA and the LOC decision and effective date are entered in the State's data management system. A "My List" function within the State's data management system helps case managers track the due dates for medical eligibility. The My List informs case managers of medical eligibility determinations that are due within 30 or 60 days. the State's data management system also has a LOC report that is used primarily by the Medicaid waiver unit during annual audits to ensure that the

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:

All waiver records are stored in the State's data management system, a web-based system that is accessible to both the operating state agency and the Medicaid waiver unit. Most forms are built into the system. Forms, reports and records that are not built into the system are uploaded into the State's data management system and stored as attachments.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC.PM1: Number and percentage of applicants who received a LOC prior to initiation of services. N= # of applicants who received a LOC prior to initiation of services D= total number of applicants

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
UCA reports, annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
LOC.PM2: Number and percentage of participant LOC redeterminations that were completed annually. N= # of participant LOC redeterminations that were completed annually D= # of participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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: Number and percentage of participant LOC determinations that were completed using the approved medical eligibility criteria N= # of participant LOC determinations that were completed using the approved medical eligibility criteria D= total number of LOC determinations that were completed

Data Source (Select one):
Other
If 'Other' is selected, specify:

OLTSS nursing reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

OLTSS conducts an annual audit of BHA's (OSA) waiver records. During these audits, OLTSS checks to make sure that LOC determinations are completed prior to the start of waiver services for participants and within 12 months of the last LOC determination for participants. OLTSS also checks to make sure that the LOC determination is completed by the Department's designated UCA.
OLTSS nurses review LOC determinations completed by the UCA to ensure that they were completed using the approved eligibility criteria.

b. Methods for Remediation/Fixing Individual Problems

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

If during the annual audit, OLTSS discovers deficiencies related to LOC determinations, OLTSS requires BHA to address the deficiency in a corrective action plan (CAP) within 30 days of completion of the audit.

If it is determined that a LOC determination was incorrect, services continue pending the outcome of a new evaluation. The UCA is consulted and an investigation is initiated to determine why the LOC was incorrect. If necessary, OLTSS initiates a request for a corrective action plan from the UCA.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

The BI Waiver case manager assists the waiver applicant and/or representative in completing a Freedom of Choice (FOC) form which requires the applicant to choose between institutional and community-based services. This FOC form also indicates the choices of services and providers that are available through the BI Waiver. The application packet is not considered complete and the applicant will not be enrolled in waiver services until the FOC form is signed.

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.

The signed FOC form, along with the other application forms, are stored in the State's data management system. Application forms, including the FOC form, are also stored in the State's data management system for those individuals who are determined not eligible for the BI Waiver.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters, at no cost to individuals, and translation of forms and documents. Additionally, interpreter resources are available for individuals who contact MDH for information, requests for assistance or complaints. The MDH website contains useful information on Medicaid waivers and other programs and resources. The State also provides translation services at fair hearings if necessary. If an 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 they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

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	Day Habilitation		
Statutory Service	Individual Support Services (ISS)		
Statutory Service	Medical Day Care		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment		

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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

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):*

The day habilitation services covered under this regulation shall be provided in a non-residential setting, separate from the home or facility in which the participant resides.
The covered services shall include:(1) Habilitative or rehabilitative services to assist a participant in acquiring, regaining, retaining, or improving the self-help skills related to activities of daily living and the social and adaptive skills, which are necessary to reside successfully in home and community-based settings; (2) One meal may be furnished as part of the program; (3) Any of the following additional services which are provided at the provider's site, are medically-necessary to prevent the participant's institutionalization, and are not otherwise covered for the participant by the Program or another payer: (a) Nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for medication administration or other delegated nursing functions provided to the participant by a qualified direct care worker; (b) Behavior intervention services; and (4) Transportation between a participant's residence and the provider's site, or between habilitation sites if the participant receives habilitation services in more than one place. (5) Services provided in a day habilitation program shall be provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of service approved by the BHA.

Level 1 requires a minimum of 1:6 staff to participant ratio.
Level 2 requires a minimum of 1:4 staff to participant ratio.
Level 3 requires a minimum of 1:1 staff to participant ratio.

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

The program shall reimburse for a participant not more than one unit of day habilitation per day or a combined maximum of seven units of supported employment and day habilitation per week. The program does not cover recreational activities not related to specific treatment goals or are solely diversional or for activities or supervision reimbursed for a source other than Medicaid. The program does not pay for day habilitation on the same date of service as on-site psychiatric rehabilitation as defined in COMAR 10.21.21 and COMAR 10.21.25. The program does not pay for day habilitation on the same date of service as adult medical day care provided under COMAR 10.09.07.

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	Day Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:

Day Services Provider

Provider Qualifications
License *(specify):*

DDA Vocational and Day Services COMAR 10.22.07

Certificate *(specify):*

Other Standard *(specify):*

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

Verification of Provider Qualifications
Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

Annually

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:
Habilitation
Alternate Service Title (if any):

Individual Support Services (ISS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
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):*

Individual Support Services is assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home or community when the provider does not have round-the-clock responsibility for the person's health and welfare. The service involves the training and development of compensatory strategies and skills such that a waiver participant may learn to initiate and complete activities on their own to fully engage in the participant's community, maintain the participant's independent living, and compensate for cognitive and behavioral deficits related to short term memory, planning, attention, concentration, impulse control, and judgement that impact a participant's ability to live independently, with the intended goal of minimizing the level of staff support the individual needs over time and to prevent institutionalization.

The service must be provided in-person but may also be supported via virtual supports using the following guidelines:

1. Virtual supports is an electronic method of service delivery used to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote his/her ability to live independently, and meaningfully participate in their community.

2. Virtual supports ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint. Video cameras/monitors are not permitted in bedrooms and bathrooms.

3. Direct support can be provided via virtual supports provided that the virtual supports meet all of the following requirements:

a. The virtual supports do not isolate the participant from integration in the community or interacting with people without disabilities.

b. The use of virtual supports to provide direct support is based on the participant's preferences, has been agreed to by the participant and their team and is outlined in the Plan of Service (POS);

c. Virtual supports will not be used for the provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the participant's Plan of Service;

d. The use of virtual supports must be documented per State requirements, policies, guidance, and regulations for daily contact notes. The service delivery method (e.g., Skype, Zoom, Facetime, telephonic, or in person direct support) must also be identified.

e. Text messaging and emailing do not constitute virtual supports.

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

g. This Waiver program service may not be provided entirely via virtual supports. Virtual supports allow flexibility of service delivery and will supplement in-person direct supports as recommended and monitored by the case manager. Virtual support will not be approved by the BHA in the POS if the health and safety of an individual requires hands on assistance.

h. The provider must develop, maintain, and enforce written policies, approved by BHA, which address:
i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meets applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.

i. The provider must train direct support staff on those policies, and advise participants and their person-centered planning team regarding the policies that address participant's needs, including health and safety, can be addressed safely via virtual supports;

j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.

k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support ISS services prior to initiation of virtual services. Provider will provide in person training to the participant to help the participant learn to use the required technology until they are able to access the platform independently.

Documentation is maintained in the file of each individual receiving this service and this waiver service(s) may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.

Individual Support Services under the waiver differ in scope, nature and provider training and qualifications from personal care services in the State Plan.

j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.

k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support ISS services prior to initiation of virtual services. Provider will provide in person training to the participant to help the participant learn to use the required technology until they are able to access the platform independently.

Documentation is maintained in the file of each individual receiving this service and this waiver service(s) may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.

Individual Support Services under the waiver differ in scope, nature and provider training and qualifications from personal care services in the State Plan.

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

Participants may receive up to 8 hours per day of Individual Support Services (ISS). Services cannot be provided to individuals receiving residential habilitation. There are no limits on duration of service.

If an individual's needs primarily require hands-on assistance with ADLs and/or IADLS, the participant will be referred to State Plan services for personal care. Participant housing costs are not reimbursable through the program.

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	ISS Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Support Services (ISS)

Provider Category:
Agency
Provider Type:

ISS Provider

Provider Qualifications

License *(specify):*

Family and Individual Support Services licensed through DDA. Provider is qualified to provide services under Maryland Regulation, COMAR 10.22.02 and 10.22.06

Certificate *(specify):*

Other Standard *(specify):*

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

Annually

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: **Sub-Category 1:**

04 Day Services	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 (MDC) is a program of medically supervised, health-related services provided in a non-institutional community-based setting to medically handicapped adults 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 meals are required to be provided. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

A. 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) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene.
(4) Nutrition services.
(5) Social work services performed by a licensed, certified social worker or licensed social work associate.
(6) Activity programs.
(7) Transportation services.

B. The Program will reimburse for a day of care when this care is:
(1) Ordered by a participant's physician semi-annually;
(2) Medically necessary;
(3) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
(4) Provided to participants certified by the Department as requiring nursing facility care under the Program as specified in COMAR 10.09.10;
(5) 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; and
(6) Specified in the participants service plan.

C. The MDC provider is responsible for arranging or providing for the provision of physical therapy and occupational therapy, when the services are required by the plan of service.

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 covered. The frequency of attendance is determined by the physician order and is part of the service plan developed by the multi-disciplinary team. Waiver participants cannot attend day habilitation or supported employment on the same day as MDC.

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

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 Qualifications

License *(specify)*:

Office of Health Care Quality is the licensing agency.

Certificate *(specify)*:

Other Standard *(specify)*:

Providers must meet the requirements of COMAR 10.09.07 for medical day care waiver providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Maryland Department of Health is responsible for verification in addition to the Office of Health Care Quality.

Frequency of Verification:

At time of enrollment and every two years during licensing reviews.

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:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
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):*

The covered service shall be rendered to individuals who reside in a DDA licensed group-home or alternative living unit that meets the Home and Community-based Settings Rule requirements.

The covered services shall include: (1) Residential habilitation, which means assistance with acquisition, retention, or improvement in skills related to activities of daily living, personal care and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting with protective oversight; (2) supervision and support, up to 24 hours a day, in a residence, based on the individual's plan of service; and (3) any of the following additional services which are medically necessary to prevent the participant's institutionalization and are not otherwise covered for the participant by the Program or another payer: (a) nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for any medication administration or other delegated nursing functions provided to the participant in the residence by a direct care worker; and (b) behavior intervention services. The residential habilitation services provider shall provide daily coordination of the participant's clinical treatment, rehabilitation, health, and medical services with the other providers of BI waiver services and the BI waiver case manager. Services provided in a residential program shall be provided and reimbursed at one of three levels of service, as pre-authorized in the participant's waiver plan of service approved by the BHA.

Level 1 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and nonawake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.
Level 2 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and awake, on-site supervision during overnight shift.
Level 3 requires a minimum of 1:1 staff to participant ratio during the day and evening shifts and awake, on-site supervision during overnight shift.

Residential habilitation is a service that allows providers to be reimbursed for absence days up to 18 days of absence annually per individual. Such payment is intended to maintain an individual's residential habilitation placement during periods of absence which may include family visitations, hospitalizations, or other overnight stays.

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

The program shall reimburse for a participant not more than one unit of residential habilitation for a date of service. In accordance with COMAR 10.09.46 the program does not cover payment for residential habilitation on the same date of service as personal care provided under COMAR 10.09.20. Additionally, the program does not cover absence days more than a total of 18 days of absence annually per individual. The Program does not cover room and board for the participant.

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	Community Residential Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Community Residential Services Provider

Provider Qualifications

License *(specify):*

DDA Community Residential Services COMAR 10.22.08

Certificate *(specify):*

Other Standard *(specify):*

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

Annually

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:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development

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):*

Supported Employment is individual employment support, including transportation assistance from the participant's residence to place of employment, for participants who, because of their disabilities, need intensive on-going support to obtain and maintain competitive, customized or self- employment in an integrated work setting at or above the state's minimum wage in a job that meets personal and career goals.

Supported employment means activities needed to support paid work in the community (in a regular work setting) by individuals receiving waiver services, including supervision and training. Supportive employment includes but is not limited to assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly worksites where persons without disabilities work. When supported employment services are provided at a worksite where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.

Level 1 requires that staff members provide daily contacts to the waiver participant.
Level 2 requires that staff members provide a minimum of 1 hour of direct support per day.
Level 3 requires that staff members provide continuous support for a minimum of 4 hours of service per day.

Documentation is maintained in the file of each individual receiving this service and this waiver service(s) may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.

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

The program shall reimburse for a participant not more than one unit of supported employment per day or a combined maximum of seven units of supported employment and day habilitation per week. The program does not cover incentive payments, subsidies, or unrelated incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to participants in a supported employment program, payments for vocational training that is not directly related to a participant's supported employment program, or for activities or supervision reimbursed for a source other than Medicaid. The program does not pay for supported employment on the same date of service as mental health vocational supported employment under COMAR 10.21.28.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

DDA Vocational and Day Services COMAR 10.22.07

Certificate *(specify):*

Mental Health Vocational Program- Supported Employment COMAR 10.21.28

Other Standard *(specify):*

Additional years of experience with BI as required in COMAR 10.09.46

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

Annually

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 OSA and Brain Injury Association of Maryland.

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):

MDH regulations require providers to conduct criminal background checks for all employees and contractual employees. The scope of the investigations is State of Maryland only. The Office of Health Care Quality checks to ensure that the criminal background checks are completed during the annual licensing audits. Additionally, BHA requires providers to submit an annual report listing all employed staff, dates the mandatory background check were completed, and the results of the background checks. BHA crosschecks this report with employee personnel files during annual provider audits.

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):

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Alternative Living Unit

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation	☐
Medical Day Care	☐
Supported Employment	☐
Individual Support Services (ISS)	☐
Residential Habilitation	☒

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation	☐
Medical Day Care	☐
Supported Employment	☐
Individual Support Services (ISS)	☐
Residential Habilitation	☒

Facility Capacity Limit:

8

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable.

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 BI Waiver program is an open process. Providers can apply to become BI waiver providers at any time. Providers can enroll by completing an application in the electronic Provider Enrollment Portal (ePREP). Completed applications are downloaded from ePREP and shared with the BHA for review and recommendation. If the provider application includes all required information and documentation, and the provider meets the provider requirements, a Medicaid provider number will be assigned. For incomplete applications and/or providers that do not meet provider requirements, BHA will continue to work with the provider until the organization meets the provider requirements or withdraws the provider application. The BHA is continuing to recruit qualified providers who have experience serving individuals with BI. Recruitment efforts include information sessions about the BI Waiver program and provider requirements, individual training and meetings with interested provider agencies, advertisements about the waiver program in the Developmental Disabilities Providers newsletter, presentations at Developmental Disabilities Administrations regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: 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:
QP.PM1: Number and percentage of providers who meet the required licensing standards prior to initiation of services N= # of providers who meet the required licensing standards prior to initiation of services D= total number of active providers

Data Source (Select one):
Other

If 'Other' is selected, specify:
Provider application

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP.PM2: Number and percentage of active providers who continually meet the required licensing standards N= # of active waiver providers who continually meet the required licensing standards D= total number of active waiver providers

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: annual provider audits staggered throughout the year	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP.PM3: Number and percentage of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements N= # of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements D= total number of active waiver providers

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

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: annual provider audits staggered throughout the year	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
QP.PM4: Number and percentage of providers who met provider training requirements according to the approved waiver requirement N= # of providers who met provider training requirements according to the approved waiver requirement D= total number of active waiver providers

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: annual provider audits staggered throughout year	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 population for this program requires that all providers are licensed. The BI Waiver does not enroll non-licensed/non-certified providers. OLTSS and BHA conduct annual provider audits. The audits are staggered throughout the year. During these audits, provider licenses are reviewed and staff credentials, background checks & training are reviewed. Participant records are also reviewed at this time.

b. Methods for Remediation/Fixing Individual Problems

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

When the State discovers that a provider does not meet 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 provider does not meet participation standards, the State immediately informs the provider and requests a corrective action plan, within 30 days, that brings the provider into compliance with qualifications. Training and technical assistance is offered to the provider by the OSA to assist with regaining compliance with program qualifications. When appropriate, funds will be recovered. Follow up occurs to ensure the corrective action plan has been implemented by the provider.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

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.
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.

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.

Please see Attachment #2.

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:

Education: Master's degree in Social Work or social service field, or Bachelor's degree in social service field with a minimum of two years of experience in case management or resource coordination, knowledge and understanding of brain injury, relevant work experience with individuals with brain injury and good communication skills.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

Waiver applicants meet with a transitional waiver case manager to receive brain injury waiver program information. Waiver participants are encouraged by waiver case managers and providers to invite any family members, friends or representatives that they chose to participate in plan of service meetings. Meetings are scheduled based on the availability of the participant and his/her invitees. The transitional case manager meets either with the applicant or the representative he/she identifies to complete the waiver application and provides a list of waiver providers and waiver services. This representative may be the legal guardian, Power of Attorney, or the legal decision maker, as identified by Maryland law. The waiver applicant’s choice of providers and services is captured on the provisional POS. This plan is finalized within 30 days of transition to the waiver and updated at least annually.

The Maryland Behavioral Health Administration (BHA), which is the operating state agency, employs a full-time trainer who assists with developing training materials for waiver providers and case managers, including person centered strategies and planning. This trainer is a certified person centered thinking trainer (Administration on Community Living). The Brain Injury Association of Maryland is also contracted by BHA to provide training and education for BI waiver providers and other HCBS partners. A Brain Injury Waiver Provider resource page has been created on BIAMD's website https://www.biamd.org/tbi-waiver-provider-membership-page.html.

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):

The Waiver Plan of Service (POS) is developed by the waiver case manager and is based on assessed participant needs as well as participant choices and personal goals.

As the core standardized assessment requirement of the Balancing Incentives Program, the Mayo Portland Adaptability Inventory (MPAI) and the Agitated Behavior Scale (ABS) have been implemented with Maryland's Brain Injury waiver in order to assess participant's needs, assist with determining eligibility, and drive service planning. This assessment is completed during the application process and annually during the re-determination of eligibility.

The POS is one of several modules within the State's data management system. The POS reflects the participant's strengths, assessed health and safety risks, risk management plan, personal goals, waiver providers, waiver and state plan service, frequency of services and associated costs. These are required fields within The State's data management system. A POS cannot be submitted without these required fields. Plans are submitted to the waiver program administrator for approval through the State's data management system.

Waiver applicants meet with a transitional waiver case manager to receive brain injury waiver program information and develop a provisional POS. A meeting is held 30 days after the transition to the community to finalize the POS. The waiver participant attends this meeting along with his/her legal representative, if applicable, and/or friends or family members the participant identifies. Also in attendance are waiver provider staff and the administrative waiver case manager. The participant is the team leader and his or her long term goals are the priority of the team. The team helps the participant identify short term goals that will help him/ her achieve the long term goals. Progress towards goals is tracked through the State's data management system. A POS meeting is held at least annually and more often if requested or if there is a significant change and the POS is updated at that time.

Monitoring of the POS is completed by the waiver case manager during face-to-face visits. The first visit is completed within the first 30 days of enrollment by the transitional case manager. Thereafter, case management visits are completed at least quarterly by the administrative case manager.

Part of the role of the case manager is to ensure that the waiver participant is receiving waiver and State Plan services identified in the plan of service. State Plan services required by individuals are scheduled and coordinated by provider staff. The case managers monitor coordination of services quarterly to ensure participants gain access to the required services and appropriate follow up occurs.

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.

Participant risks are assessed during enrollment and annually thereafter by waiver case managers and waiver providers. The Mayo Portland Adaptability Inventory (MPAI) and the Agitated Behavior Scale (ABS) have been implemented with Maryland's Brain Injury waiver program. The participant health and safety risks and a risk management plan are required fields within the POS that is built into the State's data management system. The POS cannot be submitted without completion of these required fields. Given the needs of the target population, provider based 24-hour on-call access is a requirement of the Brain Injury program. This information is also a required field within the State's data management system. The POS is submitted to the waiver program administrator through the State's data management system for approval. If any information is lacking, the State's data management system allows for a feedback and editing process between the program administrator and case manager through the State's data management system.

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.

BI waiver applicants are provided with a list of approved BI waiver providers and approved BI waiver services by transitional case managers when they apply for the BI waiver program. Applicants and/or their representatives are given a choice of BI waiver services and can choose which providers they would like to have provide those BI services.

Applicants are required to sign a freedom of choice form indicating that they have been given a choice of community based versus institutional services, a choice of services, and a choice of providers.

To facilitate informed choices of services and providers, applicants are given copies of the service proposals submitted by BI waiver providers, which includes a description of the BI waiver services, the living situation, opportunities for social support, and access to medical supports. To facilitate the applicant's choice of waiver providers and services, each waiver provider conducts a face-to-face visit with each waiver applicant in order to answer specific questions about their programs. They also arrange a tour of their program for the waiver participant and his/her family so that the applicant is able to make an informed choice. Applicants and/or their representatives document their choice of services and providers on the provisional plan of service. Participants are able to change providers and waiver services according to their needs and preferences.

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):

Service plans are created and/or approved by the operating state agency, which is part of the Medicaid agency.

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**

Specify:

The Long Term Services and Support Tracking system is a web-based system with shared access between the operating state agency and the Medicaid unit.

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.

The State Medicaid Agency (SMA) monitors implementation of the Plan of Service (POS) and participant health and welfare through case management meetings, provider audits, and reportable events. The SMA's monitoring plan includes ensuring provider compliance with all requirements associated with the provision of waiver services, including those pertaining to Individual Support Services (ISS) provided virtually.

Case Management:

The first meeting is conducted by the transitional waiver case manager within 30 days of enrollment. The transitional case manager assists the participant with identifying waiver and non-waiver services; and presents the choice of providers to the participant. The choices made by participants are documented in the State's data management system. Thereafter, annually the administrative case manager assists the participant with identifying waiver and non-waiver services; and presents the choice of providers to the participant. The participants' choices are documented in the POS captured in The State's data management system.

The administrative case management meetings are completed at least quarterly. The case management form is one of several modules within The State's data management system where information gathered during the meeting is documented. The fields on the case management form are related to participant rights, health and safety, safety of the physical site, appropriateness and provision of waiver services (e.g. staff to participant supervision ratios), whether a reportable event was discovered, and whether or not there has been a significant change and/or if a change is needed in the POS. If there is an identified problem, the report is automatically forwarded through the State's data management system to the waiver program administrator for review. Remediation is initiated as needed. Remediation, including the resolution date and a description of correction, is captured in the State's data management system. The information obtained during these meetings is used to assess the appropriateness of the POS and ensure that all needed waiver and non-waiver services have been included in the plan. If the POS is determined not to meet a participant's need, an additional POS meeting and/or POS change is made.

As described above, the administrative case manager collects information related to the appropriateness and provision of waiver services, including, as applicable, virtual supports. This interaction between the administrative case manager and waiver participant presents an opportunity for the case manager to assess whether the service of virtual supports is meeting the needs of the participant, evaluate provider compliance with the requirements of this service and to alert the SMA if issues are discovered.

Quarterly Audits:

The operating state agency waiver administrator, or designee, reviews claims for waiver services monthly via two reports to identify billing or service utilization anomalies. If the waiver administrator questions the validity of a claim, she/he will request supporting documentation from the provider. If the waiver administrator detects a pattern of anomalies, she/he may conduct an on-site review of the provider. This analysis extends to claims submitted for virtual supports. Given the requirement that providers document the method of delivery of ISS (e.g., Skype, Zoom, Facetime, telephonic, or in person direct support) in daily contact notes, the operating state agency can determine whether a provider met all requirements associated with that particular service and its method of delivery.

Annual Audits:

One hundred percent of waiver participant records are reviewed during annual provider audits, which are conducted jointly by staff from both the State Medicaid Agency (SMA) and the operating state agency. During this audit, medical and programmatic information is reviewed and the agencies compare a representative sample of paid claims with provider documentation to ensure that the service was provided as authorized. This includes ensuring that when virtual supports have been authorized, they were indeed delivered in that manner and in accordance with all State regulations and sub-regulatory guidance pertaining to virtual service delivery. In instances where there is not concordance, the provider will be required to submit supporting documentation. If a pattern of inappropriate practices is discovered, the provider will be asked to submit a plan of correction and may be further sanctioned in accordance with applicable State regulations.

The SMA and operating state agency also review a provider's emergency on-call systems and disaster plan, staff and consultant credentials, behavioral support and nursing services, and access to medical care in the community. Providers are required to have systems in place to provide 24-hour emergency on call access for direct care workers, waiver participants, and families. Additionally, providers must adhere to COMAR 10.22.10.05(B)(6) and have an effective

disaster and emergency evacuation plan, with sufficient evacuation drills in place. Per this regulation, licensed

community residential service providers offering services in alternative living units or group homes must develop an emergency plan for all types of emergencies and disasters. Procedures that will be followed before, during, and after an emergency include a protocol:

1. Ensuring that participants and staff have information regarding evacuation, transportation, or 72-hour shelter-in-place ;
2. Requiring an annual practice drill coordinated with local emergency planners for sheltering in place or evacuating;
3. Requiring preparation of an after action report and improvement plan after a drill that evaluates the plan and initiates corrective actions;
4. Ensuring that participants and staff have information regarding current health, contact, and other important information that is immediately accessible in the event of evacuation;
5. Ensuring that participants and staff have information regarding the role of the resident, family member, or legal representative in the event of evacuation;
6. Ensuring that participants and staff have information regarding arrangements for medical needs and other accommodations for participants and staff at alternative facilities or shelters; and
7. Establishing a communication protocol among all appropriate parties that includes redundant communication means.

During the annual audit, providers are also evaluated on compliance with their own policies, including those pertaining to the delivery of virtual supports. A provider's policies are subject to approval by the operating state agency upon enrollment and must address:

i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meet applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.

The annual audit provides an opportunity for the SMA and operating state agency to not only ensure that services that were reimbursed were delivered in the manner authorized and in compliance with all applicable regulatory and sub-regulatory guidance, but that the providers have effectively implemented the policies noted above which pertain directly to areas of concern in the delivery of a virtual service, including the participant's right to privacy and information security.

When problems are identified during the annual audits, the SMA will require the provider to submit a plan of corrections and the provider may be further sanctioned in accordance with applicable State regulations.

As the Brain Injury Waiver continues to be incorporated more fully into The State's data management system, the Plan of Service (POS) module will be revised to reflect the method of delivery of ISS, which will further enhance the SMA's ability to monitor provider compliance with State regulations, policies, and guidance related to the delivery of virtual supports.

Reportable Events:

Reportable events are reported through a web-based system and monitored by one of the administrative case managers. The waiver case manager ensures that events are investigated and resolved within the established RE timeframes. The reportable events data and trends are reviewed during the quarterly meeting between the SMA and operating state agency.

Monitoring of reportable events is another mechanism for:
1. Ensuring participant access to waiver services identified in the service plan;
2. Ensuring participants' freedom to choose providers;
3. Monitoring provider compliance with all requirements pertaining to service delivery;
4. Monitoring the effectiveness of back-up plans; and
5. Monitoring the participants' health and welfare.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○

Entities and/or individuals that have responsibility to monitor service plan implementation and

participant health and welfare may provide other direct waiver services to the participant.

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 States quality improvement strategy, provide information in the following fields to detail the States 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: Number and percentage of waiver participants whose plan of service addresses health and safety risk factors N= # of waiver participant plans of service that address health and safety risk factors D= total number of plans of service

Data Source (Select one):
Other
If 'Other' is selected, specify:
OLTSS Annual Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP.PM2: Number and percentage of waiver participants whose plan of service addresses assessed needs N= # of waiver participant plans of service that address assessed needs D= total number of waiver plans of service

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Case Manager quarterly visits

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP.PM3: Number and percentage of waiver participants whose plan of service addresses personal goals N= # of waiver participant plans of service that address personal goals D= total number of plans of service

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***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.PM4: Number and percentage of waiver participants that attend their plan of service meeting N= # of waiver participants that attend their plan of service meeting D= total number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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.PM5: Number and percentage of plans of service that were updated annually N= # of participant plans of service that were updated annually D= total number of plans of service

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
SP.PM6: Number and percentage of plans of service updated when warranted by changes in the waiver participants needs. N= # of participant plans of service updated when warranted by changes in the waiver participants needs. D= # of participants experiencing a change in needs that warranted an updated plan of service

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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***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.PM7: Number and percentage of individuals that received services in accordance with the plan of service (including the type, scope, amount, duration, and frequency). N= # of individuals that received services in accordance with the plan of service (including type, scope, amount, and frequency) D= # individual plans of service reviewed

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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***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.PM8: Number and percentage of participants who have a signed consent form indicating choice of waiver services and choice of providers N= # of participants who have a signed consent form indicating choice of waiver services and choice of providers D= total number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State uses three primary strategies to discover/identify problems and issues within the waiver program related to plans of service. First, waiver case managers conduct announced and unannounced quarterly visits with 100% of waiver participants to ensure that services are being provided in accordance with the plan of service and to assess whether the POC needs to be updated. Second, OLTSS and BHA conduct annual audits with waiver providers to review 100% of participant records to ensure that the waiver plans of service address participants' needs. These annual provider audits are staggered throughout the fiscal year. A representative sample of claims are matched against attendance records and clinical records to determine if services were provided as authorized. Third, OLTSS audits the waiver participant records that are located in the State's data management system on an annual basis. The audit ensures that waiver POSs address participants' personal goals, include health and safety risk factors, meet cost-neutrality limits, are updated at least annually, have signed freedom of choice forms and that participants attend their POS meetings.

b. Methods for Remediation/Fixing Individual Problems

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

If problems are discovered during quarterly case management visits or during the annual provider audit related to the plans of service or the provision of waiver services, providers are required to immediately correct the service and/or the case manager is required to schedule a meeting to update the plan of service within 2 weeks. When appropriate, such as under delivery of services to a waiver participant, funds will be recovered.

If problems are discovered during the annual OLTSS audit related to plans of service or the freedom of choice form, the OSA is required to make the corrections and provide evidence of the correction via the corrective action plan submitted to OLTSS within 30 days.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of 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.

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)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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 in 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 are aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. Each waiver participant receives a copy of the notice of fair hearing in the initial waiver application upon enrollment. The waiver participant is notified in writing that services will be continued during the appeal process. Following is the process for giving notice to applicants/participants: If an applicant or enrolled participant is denied waiver eligibility medical, technical or financial criteria he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a fair hearings notice. The Medicaid Eligibility Determination Division (EDD) sends all eligibility denial letters. Denial letters are copied to the case manager who will maintain this documentation as part of the participant waiver record. The EDD also maintains a copy. When a participant is aggrieved by a decision regarding his services or providers, the case manager is responsible for providing the participant and representative with a notice identifying the action or inaction that the participant believes is impacting him/her adversely. This written notice contains the Medicaid fair hearing rights. This notice is maintained by the case manager in the participant waiver record.

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.

The OLTSS manages the reconsideration process for medical eligibility denials. When an applicant or participant is denied medical eligibility, there is a provision for the individual to request a reconsideration while preserving the right to a fair hearing. Once a denial letter is sent, the individual/representative may request a reconsideration while simultaneously submitting an appeal letter within 10 days of receipt of the denial letter in order to continue any services. The reconsideration process begins upon request from the individual/representative and allows the individual to clarify medical information already provided regarding their health and functional status, or to provide additional information that was not included at the time of application. The utilization control agent informs the applicant/participant in writing that he/she may request a reconsideration and maintain the right to a fair hearing or elect to request a fair hearing without the interim process of reconsideration. The letter contains the standard notice with regard to fair hearing rights.

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 Operating State Agency- Behavioral Health Administration

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).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative services and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participant's representative, provider, or other interested party to any employee of BHA expressing dissatisfaction with any aspect of BHA or provider's operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Quality of care complaints include, but are not limited to, concerns about perceived practitioner's or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regard to policy and procedures, medical record documentation and confidentiality issues as well as accessibility and/or availability, which impact care. BI waiver participants are provided with a written summary of the complaint process and how to file a complaint during the initial POS meeting. BHA assists the participant as needed in completing forms. BHA will track all grievances/complaints. The process used for resolving grievances/complaints begins with the BHA representative documenting the pertinent information and the nature of the complaint on the grievance/complaints Action Report. The BHA representative addresses the issue according to the time frames outlined below. The BHA representative completes the initial investigation, and then in conjunction with the participant, family and other related parties, performs all other necessary follow-up, summarizes the finding, and determines and implements the appropriate action steps. This information will be documented on the grievance/complaints action report and submitted to the Office of Long Term Services and Supports, Division of Community Long Term Care within 30 days. Timeframes for resolving complaints are as follows: 24 hours: emergency medically-related complaints; 5 days: non-emergency medically related complaints; and 30 days: administrative service delivery complaints. Participants or their representatives will be notified of the disposition of the complaint and right to appeal as appropriate. Results will also be reported to the participant/representative and provider as appropriate. If the participant indicates that he/she is not satisfied with the response, the agency must respond in writing within 30 calendar days from the date of the agency's initial response. Individuals will be informed by the BI waiver case manager at the initial plan of service meeting that they may file an appeal for a fair hearing directly to the Office of Administrative Hearings. Filing a complaint or grievance is not a prerequisite for requesting a fair hearing.

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).

BI waiver providers are licensed by the OHCQ and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy specifically addresses incidents of abuse, neglect, death, hospital visits, injury, theft, medication errors, leave without notification, incidents requiring law enforcement or the fire department, as well as other incidents.

The providers are required to report all allegations of abuse or neglect to the BHA, OHCQ, the State's Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement within 24 hours by sending a copy of the standardized report form via email or reporting through PCIS2. Providers are required to complete an Agency Investigation Report within 10 working days of the reported incident. BHA reviews the agency's investigation results and may request additional information, determine that an on-site investigation needs to occur, or require specific actions to be taken.

Critical incidents data are collected by BHA and reviewed with the OLTSS and BIA-MD during weekly case manager meetings. In some instances, the OLTSS receives notification from BHA regarding critical allegations of abuse, neglect and exploitation. The OLTSS may initiate an independent investigation related to any serious occurrence at any time.

BHA utilizes several strategies to ensure that providers report all incidents and conduct meaningful investigations. BHA monitors all critical incidents involving BI waiver participants and summaries are maintained in a database. Waiver case managers conduct quarterly site visits. During these visits participants are surveyed to monitor the delivery of services and records are reviewed to ensure incidents and complaints have been addressed. Additionally, the BHA and OLTSS conducts annual onsite record reviews for all waiver participants. If an unreported incident is discovered during the quarterly or annual onsite visit, corrective action is requested.

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.

The transitional waiver case manager reviews the Rights and Responsibilities form, which includes information related to participants' right to be protected from abuse and neglect, during the application process. The form is completed and signed by the waiver applicant/designee prior to enrollment and annually. The form includes instructions related to reporting complaints and/or critical incidents to BHA or to the OLTSS when the complaint or incident involved a BHA employee.

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.

Providers are required to report all allegations of abuse or neglect to the BHA, OHCQ, the State's Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement within 24 hours by sending a copy of the standardized report form via email or reporting through PCIS2. BHA reviews the agency's investigation results and may request additional information, determine that an on-site investigation needs to occur, or require specific actions to be taken.

The OHCQ is primarily responsible for onsite investigations. OHCQ conducts on-site investigations based on triage categories and available information. When compliance issues are found remedies are imposed, including but not limited to requiring providers who do not adhere to the policy to submit an acceptable plan of correction.

Incidents identified as immediate jeopardy indicate there is an immediate and serious threat of injury, harm, impairment, or death of an individual.

Incidents identified as high priority indicate the individual is not in imminent danger but the incident presents a situation where a serious threat exists to the individual's health and/or safety or harm that could significantly compromise an individual's physical and/or mental health.

Incidents identified as medium priority involve a situation or presents an opportunity for harm that did not affect or would minimally affect an individual's physical and/or mental health.

The timeline for investigations follows:
1. OHCQ must initiate an investigation for incidents identified as immediate jeopardy within 2 business days. Any referrals to other agencies must be made within 1 business day of receipt.
2. OHCQ must initiate an investigation for incidents identified as high priority within 10 business days.
3. OHCQ must initiate an investigation for incidents identified as medium priority within 30 business days. Also, OHCQ must correspond with providers to ascertain the status of the participant in cases deemed medium priority.

BHA reviews all reportable incidents and investigation reports. Recommendations are made, and when necessary, additional follow-up may be initiated. Participants and/or representatives are notified 10 days after the results of an investigation.

When an investigation results in deficiencies, the licensed provider's Plan of Correction (POC) is due to the Office of Health Care Quality (OHCQ) within 10 working days of the exit conference. The POC due date may be sooner than 10 working days when the nature of the deficiency warrants a more immediate response. Upon acceptance of a provider's POC, OHCQ will forward the Statement of Deficiency (SOD) and the approved POC within 10 working days to the:

1. License Provider;

2. Complainant;

3. License Provider's Executive Director and/or Board President;

4. DDA Regional Office;

5. Maryland Disability Law Center, if appropriate;

6. Medicaid Fraud Control Unit of the Attorney General's Office, if appropriate;

7. Office of the Inspector General, if appropriate; and

8. Any other parties deemed appropriate by the OHCQ.

A copy of the SOD and the POC is forwarded to the individual receiving services who is specifically the subject to the deficient practice, and to their resource coordinator, guardian or family, as appropriate.

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. 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 responsibility of overseeing the reporting of and response to critical incidents are shared by the BHA and OLTSS. The BHA utilizes several strategies to ensure that providers report all incidents and conduct meaningful investigations. BHA monitors all critical incidents involving BI waiver participants and summaries are maintained in a database. BHA Waiver case managers conduct quarterly site visits. During these visits participants are surveyed to monitor the delivery of services and records are reviewed to ensure incidents and complaints have been addressed. If an unreported incident is discovered during the quarterly, corrective action is requested.

The BHA shares critical incident data with the SMA. The data are reviewed during coordination meetings to prevent future reoccurrence(s). Together BHA and OLTSS identify remediation strategies which may include provider remediation or technical assistance to prevent future incidents. For example, provider training may be developed, the frequency of provider auditing may be increased, the provider referrals may be frozen, or if necessary the provider's participation in the program may be revoked. Additionally, BHA and OLTSS may implement changes in program policies when systemic issues are identified. Changes in program policy are communicated to providers via Medicaid memos, transmittals and trainings.

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:

◉ **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 emphasizes the development of positive, adaptive behavior support plans based on a comprehensive functional assessment using the least restrictive behavioral techniques in order to avoid the use of restraints. Behavior plans clearly outline problem behaviors and describe them operationally and include a baseline and trend analysis for each targeted behavior. Functional alternative behaviors specifically designated to reduce each targeted problem behavior based on the functional assessment are clearly outlined and the step-by-step procedures to shape and positively reinforce these behaviors are delineated in the plan. Systematic and regularly scheduled data review of the frequency, duration and severity of the problem behaviors including environmental, antecedent, and consequent conditions allows for programs to be adjusted as needed to further avoid the use of restraints.

Brain Injury waiver providers are required to adhere to the regulations set forth in the PORII and COMAR 10.22.10, which state the emergency use of restraints is used only for the protection and life safety of the waiver participant and others. Licensed waiver providers are required to document and report the use of emergency restraints in accordance with PORII.

Regulations specify that a licensed provider must ensure that a behavior plan (BP) is developed for each individual for whom it is required. It must be developed, in conjunction with the team, by a licensed psychologist, psychology associate under the supervision of a licensed psychologist, licensed physician, licensed certified social worker, or licensed or certified professional counselor, who have training and experience in applied behavior analysis. The BP must be based on and include a functional analysis or assessment of each challenging behavior as identified in the Individual Plan (IP); specify the behavioral objectives for the individual, and include a description of the hypothesized function of current behaviors, including their frequency, severity, and criteria for determining achievement of the objectives established. The BP must take into account the medical condition of the individual. It should describe the treatment techniques and when the techniques are to be used. The BP must specify the emergency procedures to be implemented for the individual with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others; and include a description of the adaptive skills to be learned by the individual that serve as functional alternatives to the challenging behavior or behaviors to be decreased. The BP must identify the person or persons responsible for monitoring the BP; specify the data to be collected to assess progress towards meeting the BP's objectives; and as part of data collection, ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented.

Before implementation, the licensee must ensure that each BP is approved by the standing committee as specified in regulations. It must also include written informed consent of the individual, the individual's legal guardian, or the surrogate decision maker as defined in Health-General Article, §5-605, Annotated Code of Maryland. The licensed provider must ensure that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication. These techniques are only to be implemented after other methods have been systematically tried, and objectively determined to be ineffective. The licensed provider must ensure that staff do not use any method or technique prohibited by law, including aversive techniques. Staff are also prohibited from using any method or technique which deprives an individual of any basic right specified in Health-General Article, 7-1002--7-1004, Annotated Code of Maryland, except as permitted in COMAR. This includes seclusion in a room from which egress is prevented or implementation of a program which results in a nutritionally inadequate diet. In addition, staff may not use a restrictive technique as a substitute for a treatment plan, as punishment, or for convenience. There are specific COMAR that address practices and safeguards relating to: Use of Medications to Modify Challenging Behavior; Use of Physical Restraint; Use of Mechanical Restraint and Support; and Use of Chemical Restraint.

Physical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others. Providers must ensure that only staff who have been trained in the management of disruptive behavior, or other curriculum approved by the Administration, use a physical restraint and may only do so as specified in the curriculum. The provider must document in the individual's record each use of a physical restraint, including the reason for its use.

In addition to training specific to an individual’s BP, all participants providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods

of preventing or managing challenging behaviors as required by COMAR. All use of restraints and restrictive techniques must be documented in the individual's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data are reviewed as part of monitoring of the behavior plan.

The State utilizes the following methods to detect unauthorized use of restraints and/or seclusion:
The reporting of restraint is covered by the incident policy for which all licensed waiver providers are required to follow. The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of unauthorized use of restraints and/or seclusion as well as other incidents.

The BHA and the SMA conduct annual audits of licensed waiver providers to ensure behavioral supports are delivered in accordance with COMAR and the behavioral plan, which is a subset of the individual plans. Additionally, BI case managers conduct quarterly on-site interviews with participants and licensed waiver provider staff. During these visits case managers ascertain that behavioral supports are delivered in accordance with COMAR and the behavioral 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:

BI waiver providers are licensed by the Developmental Disabilities Administration (DDA). DDA designates the Office of Health Care Quality (OHCQ) to license and monitor DDA providers and to ensure compliance with state regulations. The OHCQ Developmental Disabilities Unit is responsible for overseeing the use of restrictive interventions for participants living in homes licensed by DDA.

OHCQ completes licensure surveys and investigations as necessary depending upon the severity of the critical incident. During routine licensure surveys, OHCQ staff review a sample of participant records, conduct observations, review policy/procedures and interview staff. This is to ensure that the provider is in compliance with applicable requirements including restraint usage.

Additionally, OHCQ conducts off-site and on-site investigations related to complaints/incidents which would include unauthorized/inappropriate use of restraints and guidelines for investigating/reporting. When significant deficiencies are identified during on-site complaint/incident investigations, the reports are shared with DDA, and BHA, if applicable. Additionally, prior to on-site provider audits, with OHS staff, BHA reviews survey findings. Representatives from OHCQ, BHA and OHS also attend quarterly quality council meetings and share information.

The State gathers data on the use of restraints to identify trends and patterns and support improvement strategies by compiling data from reportable events, review of behavior plans, and providers' system of internal quality assurance during annual provider audits. Data compiled from reportable events and annual audits are included in a quarterly report and are discussed during the Waiver Quarterly Coordination meetings where trends are identified and improvement strategies may be developed. Identified improvement strategies are communicated for prompt implementation through written communication directly to providers or at quarterly provider meetings.

BHA conducts annual visits with each waiver provider to ensure compliance with BI waiver regulations. At this visit, BHA reviews the most recent OHCQ site visit report to ensure that issues identified at that visit were addressed. BHA provides a quarterly report on incident/complaint data including restraint information to OLTSS staff. Provider audit information is shared with OLTSS staff. This information is shared quarterly with the Quality Council. BHA and OLTSS staff discuss waiver issues and audit findings as stated above at formal meetings and through email and telephone calls regularly.

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.

Restrictive techniques are defined as any technique that is implemented to impede an individual's physical mobility or limit free access to the environment, including but not limited to physical, mechanical or chemical restraints, or medications used to modify behavior in COMAR 10.22.01.01B(53).

In accordance with COMAR 10.22.10.05, providers must ensure that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication and is only implemented after other methods have been systematically tried objectively determined to be ineffective.

A chemical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others. Providers may only use chemical restraints in a behavioral emergency when it is ordered by a licensed healthcare practitioner and administered and monitored by a licensed healthcare practitioner. The provider must document in the individual's record the use of any chemical restraint, including the reason for its use.
COMAR 10.22.10.06C requires that the provider shall collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior. If a restrictive technique is used the provider shall:

- Convene a team meeting within five (5) calendar days after an emergency use of a restrictive technique to review the situation and action taken;
- Determine subsequent action that includes whether the development or modification of a BP is necessary; and
- Document that the requirements of COMAR has been met.

COMAR 10.22.10.06D requires that providers must ensure staff do not use:
- Any method or technique prohibited by law, including aversive techniques;
- Any method or technique which deprives an individual of any basic right
- Seclusion;
- A room from which egress is prevented; or
- A program which results in a nutritionally inadequate diet.

COMAR 10.22.10.06E prevents provider staff from using restrictive techniques:
- As a substitute for a treatment plan;
- As punishment; or
- For convenience.

COMAR 10.22.10.05C requires that before implementation of a behavior plan, the licensee shall ensure that each behavior plan which includes the use of restrictive techniques is:
- Approved by the standing committee; and
- Includes written informed consent of the individual, the individual's legal guardian, or surrogate decision maker.

Examples of restrictive techniques that are permitted as long as the COMAR listed above are followed includes:
- Wheelchair seat belts or posey to prevent falls;
- Restricting access to money;
- Cigarettes;
- Cigarette lighters;
- Sharps; and
- Physical escort to an alternative to location (in cases to reduce physical or verbal aggression.

COMAR 10.22.10.06A requires that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication; and is only implemented after

other methods have been systematically tried and objectively determined to be ineffective. Additionally, COMAR 10.22.10.06B states that the licensee shall collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior. Behavior plans are a required component of the participant's individual plan, as described in COMAR 10.22.05.05, which is required to be reviewed and updated at least annually.

COMAR 10.22.10.08A states, "Physical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others." Additionally COMAR 10.22.10.08B requires providers to ensure that only staff who have been trained in the management of disruptive behavior, or other curriculum approved by the Administration, use a physical restraint and may only do so as specified in the curriculum. The provider must document in the individual's record each use of a physical restraint, including the reason for its use.

Reporting of restraints (restrictive interventions) is covered by the DDA's Policy on Reportable Incidents and Investigations (PORII). BI waiver providers are licensed under the Developmental Disabilities Administration (DDA) regulations and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of restraints (restrictive interventions) as well as other incidents. BI waiver providers are required to follow this policy and to notify the DDA and OHCQ of a reportable incident by filing a report within the new Provider Consumer Information System (PCIS) incident module. BHA monitors the PCIS system for incidents involving BI waiver participants.

Waiver participants and families are given the BHA's contact information upon enrollment into the program to report incidents to BHA. The PORII is also available on the DDA website as a reference. Waiver participants are strongly encouraged to keep the contact information posted in their bedroom or in a location of their choosing that is easily accessible and to report all concerns.

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:

BI waiver providers are licensed by the Office of Health Care Quality (OHCQ). The OHCQ is responsible for overseeing the use of restrictive interventions for participants provided by licensed providers in accordance with regulations governing behavioral supports. OHCQ is mandated to complete annual on site surveys and conducts investigations as necessary depending upon the severity of the reportable incident or complaint.

The BHA and OLTSS monitor licensed waiver providers to ensure services, including behavioral support services and unauthorized use, over use, or inappropriate/ineffective use of restraints are provided in accordance with COMAR regulations. BHA and the OLTSS conduct annual provider audits to ensure that providers are providing services in accordance with COMAR regulations which includes the Behavior Support Services Program Service Plan. Review of participants' IP and supporting documentation such as Behavior Plans are part of the annual audit. BI case managers conduct quarterly on-site interviews with participants and provider agency staff during visits and ascertain that services, including behavioral support services, are delivered in accordance with individual plans and that participant's are satisfied with services being received.

The BHA case manager monitors reportable events to gather data regarding the use of unauthorized/authorized restrictive interventions and attends plan of service meetings where behavioral interventions and behavioral data are reviewed. Additionally, during annual audits at provider agencies, BHA and SMA review 100% of waiver participants records gathering data regarding the authorized/unauthorized restrictive interventions included in behavior plans.

Once the data are gathered, the BHA shares restrictive intervention data with the OLTSS during waiver coordination meetings. The data are reviewed during these meeting to identify trends and patterns and support improvement strategies. Together the BHA and OLTSS identify remediation strategies which may include provider remediation or technical assistance. For example, provider training may be developed, the frequency of provider auditing may be increased, the provider referrals may be frozen, or if necessary, the provider’s participation in the program may be revoked. Additionally, BHA and OLTSS may implement changes in program policies when systemic issues are identified. Changes in program policy are communicated to providers via Medicaid memos, transmittals and trainings.

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:

An incident of seclusion is deemed a Type I Reportable Incident and is reported to BHA through PCIS2. A provider agency reports the incident to OHCQ, as well as the individual's family/legal guardian. The provider agency submits the incident report to OHCQ and in some cases, MDLC within 1 business day of discovery. The agency submits the internal Agency Investigation Report (AIR) to OHCQ, BHA and MDLC (if required) within 10 business days of discovery.
Once reported, the OHCQ, BHA and OLTSS responsibilities are as follows:

OHCQ

1. Evaluate the incident report to determine the need for investigation.
2. Refer the incident to other agencies when appropriate.
3. Complete the investigation.
4. Review and approve agency's POC.
5. Provide written report with findings and conclusions to involved parties.

BHA and OLTSS:

1. Assure agency complies with reporting.
2. Assist OHCQ with investigations as requested.

○ **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.

BI waiver providers are licensed by the Office of Health Care Quality (OHCQ). The regulations and policy are based on the Maryland Nurse Practice Act and place responsibility for nursing supervision and monitoring of participant medication regimens when delegation of medication and treatments to non-nursing staff is occurring. Registered nurses (RN) must complete required training to delegate medication administration to medication technicians. Once trained, RNs are responsible for overseeing the administration of medications by medication technicians to waiver participants who are unable to self-administer their medications. All direct care staff administering medication must successfully complete the DDA Medication Technician Training Program (MTTP) and be certified by the Maryland Board of Nursing.

BI Waiver providers are required to maintain current (</= 90 days) physician orders for all medications that are to be administered to a waiver participant, assist the individual with obtaining medications from a licensed pharmacy, and assist with administering the medications in accordance with the MTTP. The community waiver provider's RN develops individualized Nursing Care Plans and provides training and supervision to Medication Technicians. Per COMAR 10.27.11, the RN assesses the health status, environment and training needs of the staff, coordinates health care needs of the participant as prescribed and recommended, and monitors the waiver participant's health minimally every 45 days.

RN assessment and monitoring must be implemented for participants with prescription medications and non-prescription medications when delegation of medication administration is required. Registered nurses cannot delegate the calculation of any medication dose, the administration of medications by IM/IV injection route, or the administration of medications by way of a tube inserted in a cavity of the body. Nursing assessments are designed to monitor the individual's health status, ascertain any medical needs and ensure the participant is receiving regular and prescribed medical care, and to detect and address any potentially harmful practices that may affect the individual's health. The RN determines the delegation of medication administration based on regulations found in COMAR 10.27.11. COMAR 10.27.11.05 outlines nursing functions and medications that cannot be delegated.

COMAR 10.22.10.07 outlines the requirements for the use of behavior-modifying medications. The requirements include documentation of the specific medications prescribed; the rationale for prescribing each medication; any alternate methods of management being used to bring challenging behavior under control; and objective data collected by staff and presented to the licensed health care practitioner (i.e. physician or psychiatrist) to indicate that the medication being used is effective in reducing the individual's challenging behavior. Regulations require that the licensed health care practitioner must review any medication that has been prescribed to modify behavior at a minimum of every 90 days, that PRN orders for medications to modify behavior are prohibited, and that medications to modify behavior may not be used in quantities that interfere with an individual's ability to participate in daily living activities. Second-line monitoring is conducted as part of the periodic monitoring of participant health and welfare by agency nurses every 45 days. Second-line monitoring nurses are required to detect potentially harmful practices, ensure follow up occurs to address harmful practices identified, and develop strategies to address complex medication regimens and behavior modifying medications.

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.

The OHCQ conducts onsite visits to licensed providers to ensure medications are managed in accordance with State regulations. Review of participants' medical charts, medication administration records, physician orders, nursing assessments, approved services, and documentation of staff medication administration training are part of the annual survey. The results of this survey are reviewed by BHA and OLTSS during the annual provider audit to ensure OHCQ cites were addressed and recommendations implemented. Additionally, medication records are reviewed during the annual audit and when reportable events concerning medication errors are submitted.

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).

The DDA regulations (COMAR 10.22.02.12) that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications state that providers must develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by DDA's curriculum on medication training. The DDA curriculum is in compliance with the Nurse Practice Act, and includes procedures for monitoring and assisting individuals with self-administering medications. All BI waiver provider nurses and staff who administer medications are trained on this curriculum. Nursing staff of BI waiver providers are responsible for overseeing the administration of medications by medication technicians to waiver participants who are unable to self-administer their medications. All direct care staff administering medication must successfully complete medication technician certification training per the Maryland Nurse Practice Act.

All nurses must comply with applicable Board of Nursing regulations including the Nurse Practice Act. The Nurse Practice Act gives nurses the ability to delegate the task of administering medication to appropriately trained staff. Based on the Board of Nursing regulations delegated medication tasks must be monitored at least every 45 days by the registered professional nurse who delegated the tasks. The individual must have a current license to practice nursing in the State of Maryland. BHA/OLTSS audits, and OHCQ licensure survey/investigative process includes ensuring that providers are qualified and in compliance with all applicable regulations/standards.

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:

OHCQ, DDA, BHA, and the Board of Nursing as applicable.

(b) Specify the types of medication errors that providers are required to *record:*

All known medication errors must be recorded.

(c) Specify the types of medication errors that providers must *report* to the state:

Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physicians assistant or nurse, any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation must be reported.

○ **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 responsibility of monitoring the performance of waiver providers in the administration of medication is shared by OHCQ, DDA, and BHA. Each DDA regional office is staffed by a regional nurse who provides training and technical assistance to nursing staff from licensed DDA providers. All three state agencies conduct annual site visits of BI waiver providers to ensure their compliance with the medication administration regulations and conduct reviews of medication administration records. It is BHA's responsibility to review the audit findings from the other two agencies. BHA investigates critical incidents related to BI waiver participants including medication errors and may enlist the support and assistance of OHCQ and DDA if the provider's response to the event is not adequate.

Problematic results from any of the above discovery processes may be addressed in a number of fashions including requiring a program improvement plan from the provider agency, a citation from OHCQ, requirements for further team planning which may necessitate a change to an individual's plan of service, consultation with the individual's prescribing physician, required changes to a provider's policy or procedure or the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction.

On a systems level, BHA uses data from surveys and critical incident reports to identify trends and develop new or revise policies, procedures, and training related to improved participant health. Information is shared and analyzed, trends/patterns and strategies are implemented to address problem areas.

Follow-up efforts are through on-going surveys, investigations and audits in order to ensure remediation has occurred or to make further changes based on issues or outcomes. OHCQ significant findings reports for DDA providers are sent to OTLSS staff.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: 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 instancesof 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: Number and percentage of participant's abuse, neglect or exploitation REs (events and complaints) with follow-up that was conducted in accordance with the RE policy . N= # of participants abuse, neglect exploitation REs (events and complaints) with follow-up that was conducted in accordance with the RE policy D= total number of REs reported to OSA

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.PM2: Number and percentage of participant REs involving abuse, neglect or exploitation where the risk to the participant was mitigated within 1 day. N= # of participant REs involving abuse, neglect or exploitation where the risk to the participant was mitigated within 1 day D= # of REs involving abuse, neglect or 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.PM3: Number and percentage of REs of abuse, neglect, exploitation or unexplained death where prevention strategies were provided. N= # of REs of abuse, neglect, exploitation or unexplained death where prevention strategies were provided D= # of REs of abuse, neglect, exploitation or unexplained death requiring prevention strategies

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.PM4: Number and percentage of participants who received education on how to report their reportable incidents and complaints at enrollment. N= # of participants who received education on how to report their reportable incidents and complaints at enrollment D= total number of participants enrolled in waiver

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual OLTSS audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.PM5: Number and percentage of participant REs (incidents and complaints) reported within 7 business days. N= # of participant REs (incidents and complaints) reported within 7 business days D= # of participant REs reported to OSA

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.PM6: Number and percentage of incidents that did not re-occur following prevention strategies. N= # of incidents that did not re-occur following prevention strategies D= # of incidents that occurred which required prevention strategies

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** 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.PM7: Number and percentage of behavioral plans that include restrictive interventions that have been approved by the Human Rights Committee. N= # of behavioral plans that include restrictive interventions that have been approved by the Human Rights Committee D= # of behavioral plans reviewed that include restrictive interventions

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.PM8: Number and percentage of waiver participants who receive an annual physical in accordance with DDA policies N= # of waiver participants who receive an annual physical in accordance with DDA policies D= total number of waiver participants

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
HW.PM9: Number and percentage of waiver participants who receive 45-day nursing assessments in accordance with DDA policies N= # of waiver participants who receive 45-day nursing assessments in accordance with DDA policies D= total number of waiver participants

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other**	

	Specify: Annual provider audits are staggered throughout the year.	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Reportable incidents and complaints are logged and tracked by the OSA.

Quarterly case management visits provide an opportunity for the case manager to discover unreported incidents and complaints. This discovery information is sent to OSA to investigate.

OLTSS' annual audit of OSA's records is the discovery strategy related to evidence of participant training on process for reporting incidents or complaints.

b. Methods for Remediation/Fixing Individual Problems

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

All incidents and complaints are logged into the Reportable Events manual tracking system. 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 RE form and tracking system.

The OSA requires providers to correctly report events discovered during the quarterly case management visits that were not reported according to the RE policy. Providers who fail to comply with the RE policy are reported to the Office of Health Care Quality and, if appropriate, sanctions are implemented.

When OLTSS, during the annual audit of the OSA's files, discovers that waiver participants have not received the required training related to reporting of events and complaints, the OSA is required to correct the problem by providing the reporting education and submitting evidence of the correction in a CAP to OLTSS within 30 days of receiving the audit findings letter.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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)

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.

BHA BI waiver program staff comprised of the Chief, Long Term Care and the BI Waiver Case Manager are responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. BI waiver staff are trained to ensure all system improvements of the BI Waiver are implemented and continuously monitored and identified problems are addressed.

Regular reporting and communications among BI waiver providers, BI waiver staff, OLTSS, the Utilization Control Agent, and other stakeholders including the BI waiver advisory council and the Quality Council facilitates ongoing discovery and remediation. BHA is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from ongoing quality improvement strategies. 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 Office of Health Care Quality, the Developmental Disabilities Administration, BHA's Administrative Services Organization, participants, family, and the BI Waiver Advisory Council. 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.
Data are received, aggregated and analyzed by BHA. Sources of data include but are not limited to: provider applications, provider audits, quarterly site visit reports, Critical incidents and complaints submitted by provider/family/caregivers. Based on the nature of this information, data are disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate spreadsheets and logs for analysis. BHA's Chief of Long Term Care reviews data, noting trends and looking for anomalies that may need immediate attention. When data analysis reveals the need for system change, BHA makes recommendations to OHS management and discusses the prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders, primarily through the forum of the Quality Council, for review and recommendations. Dependent on the nature of the system/program change required, the industry will be notified via MDH transmittals, letters, memos, email and /or posted on the MDH website. Program trends and system changes are reported to stakeholders via the annual tracking and trending report that is generated by BHA.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **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 OLTSS and BHA program staff who are responsible for the administration of the waiver, the implementation of program improvement strategies and subsequent assessment of their effectiveness. Data from critical incident reports are reviewed quarterly and data derived from BHA provider audits are assessed when they have been completed. The BHA and OLTSS participant and provider audits occur annually. Other oversight activities occur at pre-determined intervals. If a system change is needed, the OLTSS and BHA design the plan and implement the system change. Program staff provide data analysis on the change and its efficiency or effectiveness, post implementation. Data post system change will be reported during interagency coordination meetings. Once reviewed and analyzed a report compiling outcomes will be written. Data related to the change will be shared verbally and by written report with the Quality Council and other stakeholders who are engaged in the formulation of program strategies.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Administering waiver 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 flow into the waiver from many sources, such as, critical incidents and complaints, waiver performance measures, case manager quarterly reports, provider licensure data, complaint surveys/reports, fair hearings and provider audits. If the quality improvement strategy is not working as it should be, the repetition of issues and problems and unsuccessful improvement will indicate that the quality management plan must be reconfigured. Immediate actions will be taken to remediate any identified issues that require remediation. To provide structure to the periodic evaluation of the quality improvement strategy, SMA and OSA program staff will routinely involve the Quality Council. The Quality Council conducts quarterly meetings and/or communicates with the council representatives to address any specific areas of concern based on shared data including any changes in a waiver's quality improvement strategy plan.

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 presented for competitive solicitation every five years by Maryland's Comptroller's Office.

Department of Legislative Services: 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.

Behavioral Health Administration: Claims are reviewed monthly by the BHA administrator and annually during onsite audits.

Monthly claims reviews:
~~*The BHA waiver administrator receives two monthly claims reports MMIS claims report for all Medicaid claims paid during the reporting month for every waiver participant, and a waiver services report generated by the Administrative Service Organization (ASO) that includes all waiver services paid during the reporting month as well as a running total of expenditures for each fiscal year. 100% of the claims on these reports are reviewed monthly by the waiver administrator or designee to identify billing or health care utilization anomalies and evidence of unreported hospitalizations and are also utilized during annual onsite audits. If during the course of desk review, there is a question about a paid claim, a provider may be required to submit supporting documentation or an on on-site review may be conducted if there is a pattern of claims issues that require further investigation.*~~ The BHA waiver administrator or designee reviews The State's data management system and MMIS claims reports monthly for all Medicaid claims paid during the reporting month for every waiver participant. A representative sample of the claims on these reports is reviewed monthly by the waiver administrator or designee to identify billing or health care utilization anomalies, evidence of unreported hospitalizations, and are utilized during annual onsite audits. If during the course of desk review, there is a question about a paid claim, a provider may be required to submit supporting documentation or an on-site review may be conducted. If there is a pattern of claims issues that require further investigation

Annual Provider Audits: The State's annual onsite record reviews of all waiver participants include validation of claims/ billing. The annual onsite records reviews are separate from the quarterly reviews described in Appendix I-2-d. The review methodology for annual provider audits is a representative sample of paid claims compared with provider documentation to ensure that service was provided as authorized. A desk review would require validation when there is a question about a paid claim. In these instances, a provider may be required to submit supporting documentation or an on-site review may be conducted if there is a pattern of claim issues that require further investigation.

Recovery of funds are pursued by the SMA if services are not documented, not provided by qualified staff or are not provided in accordance with the participant's approved plan of service. An onsite review would be initiated if a desk review requires validation.

Audit of Provider Agencies: Medicaid has no requirement for HCBS waiver providers to obtain independent financial audits. If there are concerns about a provider's billing, OLTSS will refer the provider for an audit by Medicaid auditing staff or to the Department's Office of the Inspector General. A referral may also be made to the Medicaid Fraud Control Unit which also may conduct audits when there is a credible allegation of fraud.

ISS: ~~*The State will have an Electronic Visit Verification (EVV) system that complies with the requirements of the federal 21st Century Cures Act as passed by Congress and signed into law on December 3, 2016. The state has submitted a good faith exemption request form to The Centers for Medicare and Medicaid Services (CMS) in October 2019, requesting additional time to mitigate issues that have caused unavoidable delays. The system shall be implemented no later than January 1, 2022.*~~

~~*MDH implemented a state mandated internal EVV model in 2013, coming into full compliance for our Community Integration Programs. This solution was later leveraged to bring MDH into compliance with the Cures Act for our 1915(c) Waivers managed by the Developmental Disabilities Administration. MDH has also identified one service within the 1915(c) Waiver for Individuals with Brain Injury as requiring EVV, Individual Support Service. This service is not currently in compliance with the Cures Act requirements, but implementation using the existing EVV solution is planned by 2022.*~~
The State will expand it Electronic Visit Verification (EVV) system that complies with the requirements of the federal 21st Century Cures Act as passed by Congress and signed into law on December 3, 2016. The state submitted a good faith exemption request form to The Centers for Medicare and Medicaid Services (CMS) in October 2019, requesting additional

time to mitigate issues that have caused unavoidable delays. The system shall be implemented December 2023.

MDH utilizes a system called the ISAS IVR System, which is a telephonic verification tool. Providers clock-in and out via the telephone at the beginning and end of their shift, which captures all six required data elements. This system flows into The State's data management system, MDH's case management and provider portal system, which will verify all personal care services against pre-authorizations and other system checks. If completely successful, The State's data management system will process the clock-in and outs into claims for provider payment.

The system captures the six data elements required by the Cures Act as follows:
Type of service performed - MD EVV captures four types of services and separates these via two separate call-in and two separated items in the call flow:

CFC IVR:
a) CFC Personal Assistance
b) CFC Personal Assistance Shared Attendant

DDA IVR:
c) DDA Personal Supports
D) DDA Enhanced Personal Support.

Individual receiving the service - MD EVV identifies the individual through two methods when providers call the IVR line:
1) Phone # used is uniquely identified as the client's phone #
2) Client's 11 digit Medical Assistance #. The provider enters this in and also the 6 digit One Time Password Token, which resides with the client.

Date of the service
MD EVV records the service time at the time the provider calls

Location of service delivery
MD EVV identifies the location based on the phone # used to call into the EVV system. Phone # data is stored in the accompanying the State's data management system case management system.

Individual providing the service
MD EVV identifies the provider and caregiver by asking the caregiver to enter in the 9 digit Provider # (belonging to the agency) and 9 digit SSN (belonging to the individual)

Time the service begins and ends.
MD EVV records the service time at the time the provider caregiver calls. The caregiver must clock-in and clock-out separately for each service.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: 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: Number and percentage of waiver claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved BI waiver N= # of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved BI waiver D= total number of paid claims

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
~~***ASO monthly claims reports***~~***MMIS or*** ***The State's data management system***

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☒ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
monthly MMIS claims reports

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☒ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.PM2: Number and percentage of claims paid for participants who are eligible on the date of service. N= # of claims paid for participants who are eligible on the date of service D= # of claims paid

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Annual provider audit ~~and ASO reports~~; MMIS or The State's data management system

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		The State is reviewing a representative random sample of paid claims from all providers with a confidence interval of 95% (+/- 5%).
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
FA.PM3: Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N = # of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. D = # of claims paid reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS or The State's data management system claims data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *Confidence Interval = 95% +/- 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

~~*There are edits in the ASO claims payment system and in MMIS that ensure that BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. Monitoring of this occurs in two ways. System edits are checked annually and the OSA receives monthly claims reports from the MMIS and from the ASO. These reports are reviewed to ensure that BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.*~~

There are edits in MMIS that ensure BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. Monitoring of this occurs in two ways. System edits are checked annually and the OSA receives monthly claims reports from MMIS. These reports are reviewed to ensure that BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

b. Methods for Remediation/Fixing Individual Problems

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

~~*If system edits are not functioning properly and it is discovered that claims have been paid that are not in accordance with the reimbursement methodology in the approved waiver, the ASO will initiate a recovery of funds paid to a provider. The ASO will also initiate a recovery of funds for services provided in excess or not in accordance with the participant's approved plan of service. Technical assistance is provided to the provider by the ASO or the OSA. Continued billing errors may result in referrals to the MDH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.*~~

~~*The primary general method for problem correction in this area is provider group training by the ASO on Medicaid waiver billing. Additionally, the ASO distributes Billing Instruction Guidelines via "provider alert" to all providers and updates them as necessary to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.*~~

If system edits are not functioning properly and it is discovered that claims have been paid that are not in accordance with the reimbursement methodology in the approved waiver, the SMA will initiate a recovery of funds paid to a provider. Continued billing errors may result in referrals to the MDH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.

The primary general method for problem correction in this area is provider group training facilitated by the OSA on Medicaid waiver billing. Additionally, the the State's data management system distributes updates to providers as necessary to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Appendix I: Financial Accountability

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).

Waiver rates are based on Developmental Disabilities Administration (DDA) rate setting methodology for comparable services. BI waiver rates are located in BHA regulations, COMAR 10.21.25.

The State used the DDA-operated waiver service rates to determine the rates for the BI Waiver. The DDA-operated waiver rates are calculated based on a client and a provider component. The provider component was based on four cost centers – administrative, general, capital and transportation. The State used rate models for DDA operated waiver services that demonstrate the state's cost assumptions for the administrative, general, capital and transportation costs. Each provider's cost centers were based on costs reports submitted by providers. The client component was for direct care and also included regional rate adjustments that increased for certain high-cost areas and decreased for rural areas.

All enrolled BI providers are licensed DDA providers and are required to provide the same covered services as enrolled DDA providers. Therefore, the services in the BI waiver are comparable to the services offered in the DDA waiver. Currently, there are five providers offering four services to approximately 110 program participants. 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 State's ability to place the ten participants per year that are projected to enroll into the waiver. Additionally, there is sufficient licensed capacity for each of the services offered by BI waiver providers in the waiver.

Since the publishing of rates, ongoing amendments to rates have occurred. On a yearly basis, rates are evaluated for a Cost of Living Adjustment (COLA) as approved by Maryland's Legislature. If a COLA adjustment is approved by the Maryland legislature, the Division of Budget and Management determines an appropriate percentage increase based on the BHA's budget. In addition to rate amendments for COLAs, other rate amendments have been implemented in conjunction with policy changes to improve service delivery and better alignment with federal regulations. The State has never increased or decreased BI waiver rates based on policy changes to improve service delivery and better alignment with federal regulations. If such a change occurred the basis of the rate setting methodology would be developed in conjunction with factors relevant to the State or Federal policy change implemented to improve service delivery. BHA amends the rate section of its regulation as rate changes occur. There is a 30 day comment period as required by law.

In regard to changes to comparable DDA services to date, BI waiver services and rates have never changed as a result of changes to comparable services and rates in the DDA waiver. Please note, services and rates from the DDA waiver were used to initially establish the BI waiver services and rates.

Both Residential Habilitation and Supported Employment have three levels of acuity.

Residential Habilitation:
Residential Habilitation levels are based on staffing ratios and non-awake or awake overnight staff. The levels criteria are as follows:

- Level 1 Residential Habilitation requires 1:3 staffing ratio; non-awake overnight
- Level 2 Residential Habilitation requires 1:3 staffing ratio, awake overnight
- Level 3 Residential Habilitation requires 1:1 staffing ratio, awake overnight

Supported Employment:
Supported Employment levels are defined by the amount of staff support that is required to assist the individual with obtaining or maintaining employment. The levels criteria are as follows:

- Level 1 Supported Employment requires one contact per day (with participant or employer)
- Level 2 Supported Employment requires one hour of direct support per day
- Level 3 Supported Employment requires a minimum of 4 hours of direct support per day

Payment rate information is reflected on the revised plan of service for each participant. Rates are determined by provider type/service and are uniformed across provider types. Rate setting methodology is the same for each service type. Waiver rates are included in the participant's plan of service. The participant receives a copy of their plan of service each year.

Although the BI waiver and DDA waiver services are comparable, the tier levels are specific to the BI waiver. The DDA

services and rates are based on direct care and tied to a matrix of multiple levels of need to account for the different acuity levels.

~~Additionally, waiver rates are posted publicly on the ASO website: https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/pbhs/feeschedulesfy2021/PRP%20&%20Specialty%20Programs%20FY2021%20Fee%~~

Additionally, waiver rates are posted publicly on the MDH website:

https://health.maryland.gov/mmcp/MCOupdates/Pages/FY23-Transmittals.aspx

The entity responsible for rate determination is the operating state agency, BHA, and the SMA is responsible for oversight.
The oversight process conducted by the SMA includes:

- Verifying that rate determinations are based on comparable services within the State budget;
- Ensuring the rates are comparable to DDA rates; and
- Ensuring stakeholder input is received and considered.

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.
Subject to the limitations of the State's budget, the per diem rate shall be adjusted annually 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. The medical care cost expenditure categories include: professional services, hospital and related services, health insurance premiums, drugs, and medical equipment and supplies.

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 the 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.

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:*

~~*BI waiver providers submit claims to its limited fiscal agent an entity under contract to BHA, for claims processing. The contractor pays all claims where there are no errors or reason for the claim to be denied and submits those claims to MMIS for receipt of federal financial participation (FFP).*~~

~~*Providers are able to bill Medicaid directly for medical day care services only. An option to bill directly for all other providers is not offered or available. All other providers bill directly to an ASO.*~~
Providers will electronically bill for all Waiver services for participants based on the services and allowable units in their POSs using MMIS. The POSs will be in the the State's data management system, data management systems, and will be the basis of provider billings. The State's data management system will interface with MMIS to adjudicate claims and pay providers for rendered services. Edits and limits will be placed in the State's data management system and in MMIS to prevent overbilling and billing for services that are not authorized or in an individual's plan of service. All claims for waiver services and associated payments flow through MMIS.

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 Medicaid Management Information System (MMIS). The claim for federal funds participation (FFP) is based on the initial processing of the provider claim by the limited fiscal agent and the subsequent review of the provider claim by the Medicaid agency. MMIS edits each claim to validate the participant's waiver eligibility on the date of service. The claim is also edited for any service limitations that are specified in the BI waiver regulations, such as day habilitation and supported employment on the same day. Requests are made for federal financial participation based on claims processed through the MMIS. During the quarterly participant site visit, the BI waiver case manager validates that the participant is receiving the services indicated in the plan of service by interviewing the participant, provider agency staff and reviewing the medical record. The claim is based on the review of the paid provider claim by Medicaid. Consumer eligibility information is maintained by Medicaid and provided to the ASO on a daily basis. The eligibility information within the ASO claims processing information is updated on a daily basis based on the consumer data as provided by the ASO. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the ASO system. Claims eligible for FFP are submitted by the ASO to the Medicaid system for additional review and for the collection of FFP.~~

Payments for all waiver services are made through the Maryland Medicaid Information Systems (MMIS). There are system edits associated with the procedure codes for waiver services in the MMIS and claims validation processes in the State's data management system in which providers submit claims for payment for waiver services. Collectively, these processes ensure that claims are paid only when appropriate. Requests are made for federal financial participation based on claims processed through the MMIS.

The MMIS automatically checks for the participants' waiver eligibility on the date of service billed and rejects any claim submitted for services to participants who are not Medicaid eligible at the time the service was rendered. The claim is also edited for any service limitations that are specified in the regulations.

The plan of service (POS) in the State's data management system authorizes the provider to render and request reimbursement for waiver services. During the quarterly participant site visit, the BI waiver case manager validates that the participant is receiving the services indicated in the plan of service by interviewing the participant, provider agency staff or reviewing the medical record.

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.*

Appendix I: Financial Accountability

I-3: Payment *(1 of 7)*

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

Appendix I: Financial Accountability

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:

I-3: Payment (2 of 7)

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):*

☐ ***xThe Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***xThe 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:

~~*Maryland has a limited fiscal agent under contract from BHA. The contractor's function is to enroll eligible providers, verify authorization prior to payment, review claims and pay only Medicaid approved BI waiver rates on claims submitted by eligible BI waiver providers, provide data analysis, and conduct evaluations. The Medicaid agency oversees the claims payment system through a review of all claims paid through the limited fiscal agent. BHA instructs all BI waiver providers to bill through BHAs ASO. BHA conducts retrospective compliance reviews of a sample of BI waiver claims.*~~

☐ ***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.

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.

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:

Appendix I: Financial Accountability

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:

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

- ( ) ***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:

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.

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 §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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:*

The cost of room and board is excluded from BI waiver service rates. Waiver providers are expected to bill waiver participants for room and board expenses. Upon enrollment in the program, waiver providers sign an agreement that states that room and board costs are not included in BI waiver rates and waiver participants will be billed for room and board costs. The charge cannot exceed $420.00 monthly. Additionally, BHA sends a letter to waiver providers indicating the waiver services that are authorized for each waiver participant as they are enrolled in the program and as services change or are re-authorized thereafter. This letter also states that the waiver provider will charge room and board costs to the waiver participant.

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:

Appendix I: Financial Accountability

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:

Appendix I: Financial Accountability

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.

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: Hospital, 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	109572.86	9147.00	118719.86	98939.09	24665.95	123605.04	4885.18
2	111012.11	9574.00	120586.11	101264.49	25371.40	126635.89	6049.78
3	113387.38	10021.00	123408.38	103644.54	26097.02	129741.56	6333.18
4	116316.02	10489.00	126805.02	106080.53	26843.39	132923.92	6118.90
5	117802.82	10978.00	128780.82	108573.77	27611.12	136184.89	7404.07

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: Hospital	Level of Care: Nursing Facility
Year 1	135	27	108
Year 2	145	29	116
Year 3	155	31	124
Year 4	165	33	132
Year 5	175	35	140

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 was estimated using the actual (FY 2015 to FY 2019) average annual BI Waiver participant ALOS (total waiver days/number of service users) data. For each FY, a separate annual ALOS was calculated by LOC and then blended (or summed) together. Finally, the FY blended ALOS's were averaged to obtain the overall blended ALOS (316.03). Hilltop also calculated a five-year trend factor (0.93 percent) based on the yearly percent change in the ALOS from FY 2015 to FY 2019. This trend factor was applied to the overall blended ALOS to obtain the estimated FY 2020 ALOS. Due to the small size of the BI Waiver population, it was not prudent to apply a trend factor for WYs 1 to 5. Doing so inflated the estimated ALOS above reasonable expectations. Therefore, the FY 2020 estimated ALOS is estimated to remain stable at 318.96 in WYs 1 to 5.

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:*

The Factor estimate for D is based on the actual waiver service utilization and expenditures data for BI Waiver participants. A blended method was used to account for the two LOC's represented in the base year waiver population. The blended method multiplies the FY 2019 average cost of chronic hospital (CH) LOC services in the BI waiver by the percentage of CH LOC participants in the BI Waiver to obtain the weighted CH D.

The FY 2016, FY 2017, and FY 2019 unit cost trends were averaged to obtain the overall unit cost trend. The same was done to obtain the overall utilization trend. The overall unit cost trend and utilization trend factors were multiplied to obtain the final combined unit cost/utilization trend indexing factor. This indexing factor was applied to the FY 2019 base year weighted D to estimate Factor D for WYs 1 to 5.

To estimate individual service utilization, Hilltop calculated the percentage of unduplicated service users (number of unduplicated service users/total waiver participants) for each waiver service, per year using actual FY 2015 to FY 2019 service utilization data. We applied the FY 2019 percentage of unduplicated users for each service to the estimated annual number of unduplicated WY participants to determine the unduplicated number of participants for the BI 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.

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:*

The Factor estimates for D' is based on the actual non-waiver service utilization and expenditures data for BI Waiver participants. To obtain the weighted NF D, Hilltop multiplied the FY 2019 average cost of Maryland Medicaid-paid institutional services by the percentage of NF LOC participants in the BI Waiver. The weighted NF D' is obtained using the same population's non-institutional services.

The FY 2016, FY 2017, and FY 2019 unit cost trends were averaged to obtain the overall unit cost trend. The same was done to obtain the overall utilization trend. The overall unit cost trend and utilization trend factors were multiplied to obtain the final combined unit cost/utilization trend indexing factor. This indexing factor was applied to the FY 2019 base year weighted D' to estimate Factor D' for WYs 1 to 5.

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:*

The Factor estimate for G is based on the actual waiver service utilization and expenditures data for BI Waiver participants.

Factor G was obtained by weighting the average annual cost of FY 2019 Medicaid-paid institutional and non-institutional services by the percentage of CH and NF participants in the BI Waiver.

Based on actual waiver enrollment for FY 19, 83.5% of waiver participants have a NF LOC and 16.5 % have a CH LOC. The average G' cost FY 19 is $91,805.01 for individuals with a CH LOC, and average G' cost for FY 19 for individuals with a NF LOC is $8,989.12. The FY 19 base year weighted D' and G' is used to estimate Factors D' and G'. Factor D' is estimated using the cost trend and utilization trend methodology while Factor G' annual increase factor was the Medical Care Consumer Price Index (CPI). The weighted G' cost based on percentage of participants in each LOC is more than D'. The D' and G' trends are consistent with the figures in the last approved waiver application.

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:*

The Factor estimate for G' is based on the actual waiver service utilization and expenditures data for BI Waiver participants.

Factor G' was obtained by weighting the average annual cost of FY 2019 Medicaid-paid institutional and non-institutional services by the percentage of CH and NF participants in the BI Waiver. However, for Factor G' the annual increase factor was the Medical Care Consumer Price Index (CPI).

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.*

Waiver Services	
Day Habilitation	
Individual Support Services (ISS)	
Medical Day Care	
Residential Habilitation	
Supported Employment	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 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. 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 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						2912781.80
Day Habilitation Level 1	1 Day	1	197.00	58.78	11579.66	
Day Habilitation Level 2	1 Day	102	185.00	102.86	1940968.20	
Day Habilitation Level 3	1 Day	41	162.00	144.57	960233.94	
Individual Support Services (ISS) Total:						266673.55
Individual Support Services (ISS)	15 minutes	19	1963.00	7.15	266673.55	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	86.13	0.00	
Residential Habilitation Total:						11554144.94
Residential Habilitation Level 1	1 Day	1	356.00	228.41	81313.96	
Residential Habilitation Level 2	1 Day	95	292.00	302.30	8385802.00	
Residential Habilitation Level 3	1 Day	31	238.00	418.41	3087028.98	
Supported Employment Total:						58735.56
Supported Employment Level 1	1 Day	0	0.00	34.99	0.00	
Supported Employment Level 2	1 Day	2	17.00	58.98	2005.32	
Supported Employment Level 3	1 Day	7	56.00	144.72	56730.24	
				GRAND TOTAL:		14792335.85
				Total Estimated Unduplicated Participants:		135
				Factor D (Divide total by number of participants):		109572.86
				Average Length of Stay on the Waiver:		319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 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. 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 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						3177808.67
Day Habilitation Level 1	1 Day	1	195.00	60.29	11756.55	
Day Habilitation Level 2	1 Day	109	184.00	105.49	2115707.44	
Day Habilitation Level 3	1 Day	44	161.00	148.27	1050344.68	
Individual Support Services (ISS) Total:						285430.20
Individual Support Services (ISS)	15 minutes	20	1947.00	7.33	285430.20	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	88.34	0.00	
Residential Habilitation Total:						12564117.34
Residential Habilitation Level 1	1 Day	1	353.00	234.26	82693.78	
Residential Habilitation Level 2	1 Day	102	289.00	310.04	9139359.12	
Residential Habilitation Level 3	1 Day	33	236.00	429.13	3342064.44	
Supported Employment Total:						69400.16
Supported Employment Level 1	1 Day	0	0.00	35.88	0.00	
Supported Employment Level 2	1 Day	3	16.00	60.49	2903.52	
Supported Employment Level 3	1 Day	8	56.00	148.43	66496.64	
				GRAND TOTAL:		16096756.37
				Total Estimated Unduplicated Participants:		145
				Factor D (Divide total by number of participants):		111012.11
				Average Length of Stay on the Waiver:		319

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. 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 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						3452424.93
Day Habilitation Level 1	1 Day	1	194.00	61.83	11995.02	
Day Habilitation Level 2	1 Day	117	182.00	108.20	2304010.80	
Day Habilitation Level 3	1 Day	47	159.00	152.07	1136419.11	
Individual Support Services (ISS) Total:						304943.52
Individual Support Services (ISS)	15 minutes	21	1931.00	7.52	304943.52	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	90.60	0.00	
Residential Habilitation Total:						13739343.05
Residential Habilitation Level 1	1 Day	1	350.00	240.26	84091.00	
Residential Habilitation Level 2	1 Day	109	287.00	317.99	9947681.17	
Residential Habilitation Level 3	1 Day	36	234.00	440.12	3707570.88	
Supported Employment Total:						78331.77
Supported Employment Level 1	1 Day	0	0.00	36.80	0.00	
Supported Employment Level 2	1 Day	3	16.00	62.04	2977.92	
Supported Employment Level 3	1 Day	9	55.00	152.23	75353.85	
				GRAND TOTAL:		17575043.27
				Total Estimated Unduplicated Participants:		155
				Factor D (Divide total by number of participants):		113387.38
				Average Length of Stay on the Waiver:		319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 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. 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 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						3747126.96
Day Habilitation Level 1	1 Day	2	192.00	63.42	24353.28	
Day Habilitation Level 2	1 Day	124	181.00	110.97	2490610.68	
Day Habilitation Level 3	1 Day	50	158.00	155.97	1232163.00	
Individual Support Services (ISS) Total:						339409.62
Individual Support Services (ISS)	15 minutes	23	1914.00	7.71	339409.62	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	92.92	0.00	
Residential Habilitation Total:						15025267.63
Residential Habilitation Level 1	1 Day	2	347.00	246.41	171008.54	
Residential Habilitation Level 2	1 Day	117	285.00	326.13	10874804.85	
Residential Habilitation Level 3	1 Day	38	232.00	451.39	3979454.24	
Supported Employment Total:						80338.59
Supported Employment Level 1	1 Day	0	0.00	37.74	0.00	
Supported Employment Level 2	1 Day	3	16.00	63.63	3054.24	
Supported Employment Level 3	1 Day	9	55.00	156.13	77284.35	
				GRAND TOTAL:		19192142.80
				Total Estimated Unduplicated Participants:		165
				Factor D (Divide total by number of participants):		116316.02
				Average Length of Stay on the Waiver:		319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 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. 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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						4036367.16
Day Habilitation Level 1	1 Day	2	190.00	65.04	24715.20	
Day Habilitation Level 2	1 Day	132	179.00	113.81	2689102.68	
Day Habilitation Level 3	1 Day	53	156.00	159.96	1322549.28	
Individual Support Services (ISS) Total:						360316.32
Individual Support Services (ISS)	15 minutes	24	1898.00	7.91	360316.32	
Medical Day Care Total:						0.00
Medical Day Care	0	0	0.00	95.30	0.00	
Residential Habilitation Total:						16129206.88
Residential Habilitation Level 1	1 Day	2	344.00	252.73	173878.24	
Residential Habilitation Level 2	1 Day	124	282.00	334.48	11696096.64	
Residential Habilitation Level 3	1 Day	40	230.00	462.96	4259232.00	
Supported Employment Total:						89602.68
Supported Employment Level 1	1 Day	0	0.00	38.71	0.00	
Supported Employment Level 2	1 Day	3	16.00	65.26	3132.48	
Supported Employment Level 3	1 Day	10	54.00	160.13	86470.20	
				GRAND TOTAL:		20615493.04
				Total Estimated Unduplicated Participants:		175
				Factor D (Divide total by number of participants):		117802.82
				Average Length of Stay on the Waiver:		319