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:

The following changes are being made for this renewal application:

*Removal of Certified Nursing Assistant/Home Health Aide and Certified Nursing Assistant/Home Health Aide shared services: A review of service utilization revealed that no more than 1 participant per year used these services since Fiscal Year 2016. The delegated Nursing Services rendered by certified nursing assistants and home health aides who are also certified as medication technicians remains a waiver service.

**While not addressed in this renewal, the Department plans to implement Electronic Visit Verification for private duty nursing services in Fiscal Year 2024 pursuant to it's receipt of CMS' approval of the states Good Faith Effort exemption request. Waiver amendments will be submitted prior to implementation.

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*):

Model Waiver for Fragile Children

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.40118
Draft ID: MD.008.08.00

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

Model Waiver

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

07/01/23

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

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

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

○ **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:

○ **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.

Purpose:
The purpose of the Model Waiver (MW) is to provide home and community-based services to medically fragile individuals who, before the age of 22, would otherwise be institutionalized.

Goals:
The goals of the Model Waiver are to:
*Enable 200 medically fragile children to live and be cared for at home rather than in an institution;
*Provide quality services; and
*Ensure the well-being and safety of the individuals served.

Objectives:
The objectives are to:
*Provide health support services to waiver participant's to maximize optimal health functioning and independence;
*Provide support to the family and/or caregivers.

Organizational Structure:
The Maryland Department of Health (MDH) is the single State agency charged with the administration of Maryland's Medicaid Program. The Office of Long Term Services and Supports (OLTSS), Division of Nursing Services (DONS) is responsible for the operation and oversight of the MW within the Department of Health. The DONS is responsible for the day-to-day operations of the waiver and the administrative responsibilities associated with a waiver. The DONS MW Nurse Consultant interacts on a daily basis with case management staff, participants or their caregivers, other provider agencies, physicians, etc. to handle complaints, ensure resolution of Reportable Events, preauthorize services, review level of care determinations review and approve participants' Plans of Care, etc.

The Office of Health Care Quality (OHCQ)within MDH licenses program providers for nursing and home health aide/certified nursing assistant-certified medication technician services.

Service Delivery:
Services provided through the waiver include:
*Private duty nursing;
*Certified nursing assistant/ home health aide-certified medication technician;
*Case management;
*Physician participation in the Plan of Care development; and
*Medical daycare.

Case management services are provided to the participants via an enrolled Medicaid provider who works closely with the participant and/or his legal representative as well as the MW's Nurse Consultant employed by the DONS. The case management staff perform a number of duties associated with the waiver including coordinating the eligibility process, scheduling the participant's Plan of Care meeting, developing the participant's Plan of Care, etc. In addition, case managers monitor the delivery of service to ensure they are being delivered in accordance with the participant's approved Plan of Care.

All services in the participant's Plan of Care are provided via enrolled Medicaid providers. Services which they receive include both State Plan services and services covered under the waiver.

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:

MDH obtained ongoing public input into the development and operation of the waiver in a variety of ways. A Model Waiver Advisory Committee was established a number of years ago to provide an on-going forum for stakeholders to provide input to MDH. The Advisory Committee is comprised of provider representatives, participants, family members and MDH waiver staff. The Advisory Committee discusses proposed regulations, policy changes, waiver amendments and renewals and any other topic related to the Model Waiver.

Regular updates about the Model Waiver are provided to the Medicaid Advisory Committee.

A notice is published in the Maryland Register when new or amended regulations are proposed by MDH. Regulations may not be promulgated until an opportunity for public comment is provided including a response from MDH to all public comments received. Additionally, a notice must be placed in the Maryland Register when a waiver is initiated, amended or renewed.

The Model Waiver Renewal Application's (effective July 1, 2023) request for public input was posted in the Maryland Register on February 15, 2023 and made available electronically or in hard copies at the local health departments and the Maryland Department of Health.
The Public Comment Period was held from February 15, 2023 through March 17, 2023.

The Waiver renewal application was also posted on the Maryland Department of Health's website on _____ at the following link:
_____

Notification (dated February 17, 2023) of the posting of the Waiver renewal application was sent to the Maryland Urban Indian Organization (UIO) for Tribal Consultation at the following address:

Native American LifeLines
106 West Clay Street
Baltimore, MD 21201

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: Smith

First Name: Jamie

Title: Deputy Director, Nursing and Waiver Services

Agency: Maryland Department of Health

Address: 201 W. Preston Street, Room 135

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-1442 **Ext:** ☐ **TTY**

Fax: (410) 333-5212

E-mail: jamie.smith1@maryland.gov

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

Last Name: Williams

First Name: Dawnn

Title: Chief, Division of Nursing Services, Office of Health Services

Agency: Maryland Department of Health

Address: 201 W. Preston St. , Room 130

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21021

Phone: (410) 767-1596 **Ext:** ☐ **TTY**

Fax:

(410) 333-5085

E-mail:

dawnn.williams@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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Maryland**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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 and as outlined in the Maryland Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:

Office of Long Term Services and Supports--Division of Nursing Services

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Medicaid utilizes the services of a contracted Utilization Control Agent (UCA) to render initial and annual level of care determinations for medical eligibility. The current five-year contract began work in February 2016. An extension of the current contract was executed through July of 2023 to allow sufficient time to competitively solicit under a new contract beginning August 1, 2023.

○ **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:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the

state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of Long Term Services and Supports (OLTSS) within the State Medicaid Agency (SMA) contracts with a Utilization Control Agent (UCA) to perform level of care determinations. The OLTSS Administration staff is the contract administrator/monitor for the UCA contract.

Determinations are considered timely when the UCA renders a decision within 3 business days of receipt of all requested documentation. When a determination is made by the UCA nurse to deny LOC, a second review is conducted by the Medicaid program staff (Medicaid Physician Consultant and/or MW Nurse Consultant) prior to issuance of the denial.

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

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

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

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
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	☒	☐

Function	Medicaid Agency	Contracted Entity
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	☒	☐

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:
AA3: Percent of complete & accurate participant records; Numerator: Total # of complete & accurate participant records; Denominator: Total # of participant records reviewed

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: Random sample of 15% of MW participants files
	☐ **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:
AA4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. Numerator: # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. Denominator: # of quarterly meeting scheduled during the fiscal year.

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: Case Management agency	☐ **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:
AA5: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N: # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D: # of providers

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:

Performance Measure:
AA2: % of substantiated cases of abuse, neglect or exploitation for which the Medicaid Agency implemented appropriate remediation strategies in a timely manner Numerator: Total # of substantiated cases of abuse, neglect or exploitation for which appropriate remediation strategies were implemented in a timely manner Denominator: Total # of substantiated cases of abuse, neglect or exploitation

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**

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:

Performance Measure:
AA1:Percent of oversight meetings with case management provider; Numerator: Total # of weekly meetings; Denominator: Total # of weeks

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:

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

The SMA will provide oversight of the waiver by continuing to meet with the case management provider's staff on a weekly basis. All activities completed by the case management provider staff are entered into the LTSSMaryland data management System. The SMA monitors all case management agencies through reports built into the system, and as the need arises, custom reporting. This includes an evaluation of all functions, including developing and submitting plans of service (POS), submitting reportable events (RE) and the associated intervention and action plans, and submitting activities for reimbursement in line with the solicitation. Identified deficiencies require that the case management agency submit an acceptable corrective action plan (CAP) to the SMA. The case management agency receives a letter indicating when the review has been successfully closed and the CAP has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the required functions of the case management agency. In addition, the SMA will review the results of the annual customer satisfaction survey to help identify problems/issues within the waiver and review performance measures with the case management provider on a quarterly basis.

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.

The SMA will provide technical assistance and/or education to the case management provider's staff on an issue by issue basis. Areas identified by waiver participants as needing improvement or non-satisfactory will be reviewed by SMA staff and plans to address the area(s) will be drafted and reviewed by the appropriate entity such as the MW Advisory Committee, departmental management, providers, etc.

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 Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☒	Medically Fragile	0		☒
	☐	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:

Must:
1) meet hospital or nursing facility level of care,
2) apply to the waiver prior to the age of 22 years,
3) have disabilities and needs for home care which cannot be adequately addressed through provider services otherwise available under the Medicaid Program, and
4) meet the financial criteria required for waiver participation.

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 cost of the services needed by the individual and approved in the individual's Plan of Care (POC) are calculated prior to his/her enrollment in the waiver to ensure that the services the individual receives in the community do not exceed those which he/she would require and receive in an institutional setting.

If waiver entrance is denied, the individual is notified of the opportunity to request a Fair Hearing.

The waiver participant is notified in writing of all denial or reduction of services and apprised of his right to request a Fair Hearing within 90 days. In addition, the written notice advises the individual that services will be continued during the appeal process if the aggrieved action is appealed within the 10-day continuation of benefits period. Participants and/or their representatives may receive assistance applying for a fair hearing if requested from a provider or their case manager. Information is in the packet that is sent to the participant and/or representative regarding the adverse action, the Summary of Procedures for a Fair Hearing reflects contact information related to Legal Aid and Disabilities Rights Maryland (formerly Maryland Disability Law Center). This document also informs the participant that additional information can be submitted and will be reviewed before the hearing if the participant requests a reconsideration. This information is explained and reviewed with the participant during the multidisciplinary team meeting process as well.

Applicants and waiver participants are advised of their right to request a fair hearing by the following entities:

The UCA when a qualifying LOC is denied;
MDH when waiver or State Plan services are denied or reduced; and
MDH when an applicant is denied waiver eligibility.

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:

All opportunities to revise the Plan of Care are explored if a participant can no longer be served in a cost-neutral manner. In the event there is no solution available, the case manager will develop a discharge plan with the participant and representative(s) which may include referring the participant to the local health department, Maryland Access Point (MAP), Adult Evaluation and Referral Services program, to provide detailed assistance in identifying non-waiver community resources and other support services. Participants may also be referred to the Medicaid group who conduct monthly Coordination of Services meetings. The members of this meeting group help to evaluate available individual options which may include making recommendations and referrals to other waiver or Medicaid programs. The Medicaid unit of the local department of social services is also a typical referral source when there are issues related to Medicaid eligibility.

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	220
Year 2	220
Year 3	220
Year 4	220
Year 5	220

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	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

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:

The individuals selected for participation in the MW must:
1) meet the qualifying LOC,
2) demonstrate that they meet cost neutrality, and
3) have a POC that ensures health and safety in the community via waiver and State plan services.

Costs to the State for services received in the community shall not exceed that of institutional care. In addition, individuals are selected in accordance with the Model Waiver's pre-qualified prioritized waiting list process. This pre-qualified prioritized waiting list identifies individuals who medically and technically qualify for the Model Waiver and for whom capacity is not currently available. Medically and technically pre-qualified individuals are prioritized based upon specific criteria and placed in one of 6 categories. The 6 categories are prioritized based upon the degree of unmet need and risk of institutionalization. An individual's placement in any of the categories may be fluid based upon his/her changing needs.

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)**
- [ ] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **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:

Children for whom adoption assistance or foster care maintenance payments are made under title IV-E (42 CFR §435.145)

Medically needy individuals under 21 years of age (42 CFR§435.308)
Individuals who meet the income and resource requirements of the cash assistance programs (42CFR§435.210)
Optional coverage of the medically needy (42CFR§435.301 Subpart D)
Children and pregnant and postpartum women at or below 250% of FPL (42CFR§435.116)
Newborn children (42CFR§435.117)
Children at least 1 year old under 6 years of age with family incomes at or below 133% FPL (42CFR§435.118)
Children at least 6 years old and younger than 19 years of age with family incomes at or below 100% FPL (42CFR§435.118)

Optional targeted low-income children 1902(a)(10)(A)(ii)(XIV)
State subsidized adoption assistance 1902(a)(10)(A)(ii)(VIII)

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:

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 Maryland Department of Health (MDH) contracts with a Utilization Control Agent (UCA) to conduct initial determinations as well as annual re-determinations of medical eligibility.

- ( ) **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 UCA employs licensed registered nurses to determine LOC. The UCA employs a physician, as does MDH, who will assist in the determination of LOC when there are unusually complex or contested decisions by the nurse reviewers. All LOC determinations are subject to the review and approval of 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 required for eligibility for MW participation is hospital or nursing facility LOC. The UCA uses standardized LOC evaluation tools to assess each individual for hospital or nursing facility LOC. The tool used to determine the individual's LOC is either the 3871 forms.

Nursing Facility Level of Care
Maryland's nursing facility level of care is set forth in Nursing Facility Transmittal 213. The criteria are the same for all programs requiring NF LOC. The criteria are as follows:

Nursing facility services are services provided to individuals who, because of their mental or physical conditions, require 1) skilled nursing care and related services, 2) rehabilitation services, or 3) on a regular basis, health-related services above the level of room and board.

Full definitions and guidance related to the NF LOC standard can be found in the original transmittal at the following link.
https://mmcp.dhmh.maryland.gov/docs/PT%2032-08.pdf

Chronic Hospital Level of Care
Chronic hospital level of care criteria is set forth in COMAR 10.09.93 as follows:

(1) Complex respiratory care services;

(2) Complex wound care services;

(3) Services for participants with multiple co-morbidities, including but not limited to services necessary to care for:

(a) Ventilator-assisted individuals who have been ventilator dependent for less than 6 months and who need further medical stabilization or are candidates for weaning from ventilator assistance;

(b) Tracheostomy participants who require suctioning more frequently than every 2 hours or are candidates for decannulation;

(c) More than two extensive stage IV decubiti which require daily intensive treatment that is not available in a nursing facility; or

(d) Extensive post-operative or post-traumatic care with multiple drains or extensive dressing change or therapies beyond the capabilities of a nursing facility;

(4) For participants admitted for intensive rehabilitation services, at least two sessions, 5 days per week, of physical therapy, occupational therapy, or speech therapy focused on language pathology; and

(5) Ancillary services.

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 individuals physician completes and signs the 3871 form which is then submitted to the UCA for determination of LOC. A letter is sent to an applicant or participant who is determined to meet the medical eligibility criteria. If an individual is denied a qualifying LOC, a denial letter is issued with the right to request a fair hearing. Enrolled participants are reevaluated at least annually for LOC.
The same process is used for both the initial and reevaluation determinations.

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 DONS Nurse Consultant for the MW monitors timely re-evaluations of LOC submitted and processed by the UCA. The Nurse Consultant reviews a list of those individuals who are due re-certifications with the case management provider on a monthly basis. In addition, the Nurse Consultant validates that a re-determination of LOC has been received for each individual on a monthly basis.

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:

Records of evaluations and re-evaluations of LOC are maintained by the UCA for a minimum of 3 years. In addition, the DONS maintains a copy of the LOC determination in the participant's records for a minimum of 6 years.

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:
LOC2: Percent of LOC determination made timely by the UCA; Numerator: Total # of timely (within 3 business days of receipt) initial LOC decisions; Denominator: Total # of initial LOC decisions

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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:
LOC1: Percent of initial level of care determinations made; Numerator: Total # of initial LOC determinations; Denominator: Total # of waiver applicants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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:

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

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:
LOC3: Percent of LOC determinations made every 12 months; Numerator: Total # of LOC re-determinations; Denominator: Total # of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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 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:
LOC4: Number and percent of LOC initial determinations completed according to State policies and procedures. Numerator: number of LOC initial determinations completed according to State policies and procedures. Denominator: number of initial determinations reviewed.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
In addition, the LOC determination notice is reviewed by OHS staff upon receipt for appropriateness.

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: semi-annually

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 DONS Nurse Consultant reviews the LOC determinations monthly. If the LOC determination differs from the participant's prior LOC and there have been no major changes in the participant's medical needs/condition, the Nurse Consultant requests a review of the determination to confirm its accuracy.

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.

Program staff will work with UCA to ensure timeliness of initial and re-determination LOC decisions. The SMA performs a review of UCA performance for timeliness and appropriateness of initial and re-determination LOC decisions. If the review results indicate on-going, systemic problems in LOC decision-making, the SMA will pursue a series of corrective actions including convening clinical staff to review cases in dispute and identify areas where additional training may be required. The SMA may also conduct training for the UCA's staff. If training fails to improve the UCA's performance, the SMA will increase the level of Departmental involvement in the decision-making process before issuing notices to waiver applicants and participants. If these efforts fail to improve performance, the SMA will pursue financial sanctions against the UCA and, as a last resort, terminate the UCA's contract.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 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 MW case manager assists the waiver applicant or his/her parent/guardian in completing a Freedom of Choice form which requires the applicant to choose between institutional and community-based services. The application packet is not considered complete and the applicant will not be enrolled in the MW until the Freedom of Choice form is signed. The Freedom of Choice form reflects the individual's or his legal representative's election of community-based vs. institutional services. The form does not contain information about the services that are available under the waiver. This information is presented to the applicant or his legal representative at the time the case manager performs the home assessment, prior to enrollment in the waiver.

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 original Freedom of Choice form is maintained in the participant's permanent record in the LTSS data management system for a minimum of three years.

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 participants and translations of forms and documents. Additionally, interpreter resources are available for individuals who contact the SMA for information, requests for assistance or complaints.

The Maryland Department of Health (MDH) website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at 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	**Case Management**		
Statutory Service	**Medical Day Care**		
Extended State Plan Service	**Private duty nursing service**		
Other Service	**Principal Physician's Participation in the Plan of Care Meeting**		

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:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case management includes locating, arranging, monitoring and coordinating the comprehensive package of health-related services necessary in meeting the identified need of the waiver participant as specified in his or her POC. Each case manager is licensed as a registered nurse.

The case management provider is required to have a written agreement with each participant which includes the following:

• A description of the types, amount, frequency, and duration of home care services to be provided to the participant as ordered by the principal physician and specified in the approved plan of care;

• A statement that the participant or responsible representatives have access to the individual plan of care and will be involved in its development and periodic review;

• The name, address, telephone number, and Medical Assistance number of the participant;

• The dated signatures of the participant or legally authorized representative, and the provider representative;

• A statement that utilization of available services and selection among approved enrolled providers is subject to participant choice;

• A statement that services will at all times be provided without discrimination with regard to race, color, age, sex, national origin, marital status, or physical or mental challenge.

The agency must be available to participants at least 8 hours a day, 5 days a week with established hours of operation and maintain written and implemented formalized policies and procedures developed before participation concerning:

• Medical records for each participant which include at a minimum the application for home care, plan of care, orders for home care services, documentation of nursing observations at least every 30 days, social history, and home care cost worksheets establishing initial participant eligibility and continued eligibility on a quarterly basis;

• Utilization review which includes the development of a home care review procedure completed every 6 months for all participants to evaluate the appropriateness of home care, the efficiency, adequacy, and coordination of home care services, with the objective of achieving the least costly yet appropriate delivery of services under the waiver.

The case management agency is responsible for convening the multidisciplinary team which:
• Upon receipt of the principal physician's orders assesses the appropriateness of home care for the participant;

• Determines the medical, psychological, social, and functional status of each participant;

• Develops an individual plan of care in conjunction with the principal physician's orders; and

• Reviews and updates the individual plan of care.

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

There are no arbitrary limits on the amount, frequency or duration of the services.

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	Case management agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case management agency

Provider Qualifications

License *(specify):*

The case management agency must meet all applicable licensure and certification requirements of the jurisdiction in which the agency is providing services and not be a provider of medical supplies and equipment or nursing services. Each case manager is licensed as a registered nurse.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Nursing Services (DONS)

Frequency of Verification:

Upon enrollment as a waiver provider
Medicaid provider revalidation is a requirement from 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

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):*

A. Medical day care (MDC) is a medically supervised day program.

B. Medical day care includes the following services:

1. Health care services;
2. Nursing services;
3. Physical therapy services;
4. Occupational therapy services;
5. Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene;
6. Nutrition services;
7. Social work services;
8. Activity programs; and
9. Transportation services.

Service Requirements

A. Provided to participants certified by the Department as requiring nursing facility care under the Program.

B. A participant must attend the medical day care a minimum of four (4) hours per day for the services to be reimbursed.

C. Medical day care services are provided to participants aged 16 and older.

Services and activities take place in non-institutional, community-based settings.

Services are generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a noninstitutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

The services under medical day care services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Prior to accessing waiver funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services (“DORS”), State Department of Education, and Department of Human Services, must be explored and exhausted. These efforts must be documented in the participant’s file. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Medical day care was added to the Program during the waiver renewal effective July 1, 2008. Medical day care is a program of medically supervised, health-related services provided in an ambulatory setting to medically handicapped individuals who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living. Although this is a covered service under the MW, only two participants have elected this service since its implementation. Eligibility for MDC program is 16 or older. A small percentage of MW participants are over the age of 16. Few MDC Centers in Maryland target this young population. While eligible for the service, most MW participants in this age group elect in-home services. As the participants' age and/or the number of MDC Centers targeting a younger population expand, utilization of this service is expected to increase.

.

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

There are no arbitrary limits on the amount, frequency or duration of the service.

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):*

Licensed by OHCQ

Certificate *(specify):*

Other Standard *(specify):*

Meet the requirements of COMAR 10.09.07 for medical day care providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDH, Office of Long Term Services and Supports
MDH, Division of Nursing Services

Frequency of Verification:

Current licensure is verified at the time of provider enrollment; the OHCQ notifies OLTSS staff if licensure is not renewed terminated, suspended, etc.
Medicaid provider revalidation is a requirement from 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

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:

Extended State Plan Service

Service Title:

Private duty nursing service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05010 private duty nursing
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):*

Services are provided when nursing services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the State plan. The provider qualifications specified in the State plan apply. Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed practical nurses and registered nurses within the scope of State law. These services are provided to a participant at home or where normal life activities take the participant outside of the home. This waiver service is only provided to individuals age 21 and over. All medically necessary private duty nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Delegated nursing services are included under the state plan's PDN program. These services are provided by certified nursing assistants and home health aides that are also certified as medication technicians. The scope and nature of these services do not differ from services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply. This waiver service is only provided to individuals age 21 and over. All medically necessary delegated nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

There are no arbitrary limits on the amount, frequency or duration of the services. Services must be medically necessary, physician-ordered, the cost of all services provided under the individual's POC must be cost neutral and directly related to the POC. Services which are for the convenience or preference of the recipient or the primary caregiver rather than as required by the participant's medical condition are not covered nor are services which duplicate or supplant services rendered by the participant's family or primary caregivers as well as other insurance, privilege, entitlement, or program services that the participant receives or is eligible to receive.

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	Licensed residential service agencies (RSA)
Agency	Medicare certified home health agencies (HH)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Private duty nursing service

Provider Category:

Agency

Provider Type:

Licensed residential service agencies (RSA)

Provider Qualifications

License *(specify):*

RSA license issued by the States OHCQ

Certificate *(specify):*

Other Standard *(specify):*

Training:
The DONS staff is responsible for enrolling providers to render private duty nursing and/or home health aide/certified nursing assistant services to waiver participants. The provider applicant initially submits an application to the Provider Enrollment unit, which pends the application in MMIS and then forwards the pended application to the DONS. The DONS existing provider enrollment policy requires applicants for provider status to attend an educational session prior to completion of the provider enrollment policy. The final internal requisite paperwork to complete the enrollment process will be done upon a provider applicant's attendance of the educational session. Failure to attend an educational session will result in non-completion of the enrollment process and a denial of provider status. Descriptions of all Provider Trainings are as follows:

1. Provider Applicant Training: This training is for provider applicants prior to their potential enrollment as Medicaid Nursing Services providers. The training was implemented after it was discovered that applicants required clarification related to program requirements and the enrollment process. Applicants are given the information prior to continuing with the application for enrollment. After learning more about the program and its requirements, some providers may choose not to continue with the application process and are referred to other Medicaid programs of interest to them.

2. New Provider Education/Training: This training is the final step for the provider applicant prior to their enrollment. This training provides information on the regulations, preauthorization, participant eligibility, etc. Upon completion of this training, the provider is enrolled as a Nursing Services provider.

3. Provider Training: This training is for enrolled providers. This training is held when the State discovers trends of varying areas of non-compliance or areas of clarification and determines that technical assistance/education is required or the State aims to inform providers about newly established procedures, regulatory amendments, and/or audit trends.

4. Provider One-to-One Training: This training was implemented in September 2015 and is also held for enrolled providers. The State's intent is to remain proactive by offering this training to providers to inform them of best practices. As determined by the State, based on audit reviews, the State may initiate this education. Providers may also request this training for technical assistance. This training will review overall requirements and address any concerns specific to each provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DONS
OHCQ

Frequency of Verification:

Verification of current licensure is required prior to provider enrollment as well as on an annual basis. Medicaid provider revalidation is a requirement from 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Private duty nursing service

Provider Category:

Agency

Provider Type:

Medicare certified home health agencies (HH)

Provider Qualifications

License *(specify):*

Home Health Agency license issued by the States Office of Health Care Quality (OHCQ)

Certificate *(specify):*

Other Standard *(specify):*

Medicare certified and enrolled as a Medicare provider
Home Health Agencies also provide State Plan home health services. These services differ from private duty nursing in that the services provided (i.e., skilled nursing, physical therapy, speech therapy, occupational therapy, and home health aide) are rendered as intermittent visits rather than the continuous care provided under private duty nursing. The State Plan requires Medicare certification for Home Health Agencies.

If providing private duty nursing, the home health agency must undergo the same trainings as the Residential Service Agency as noted below.
Training:
The DONS staff is responsible for enrolling providers to render private duty nursing and/or home health aide/certified nursing assistant services to waiver participants. The provider applicant initially submits an application to the Provider Enrollment unit, which pends the application in MMIS and then forwards the pended application to the DONS. The DONS existing provider enrollment policy requires applicants for provider status to attend an educational session prior to completion of the provider enrollment policy. The final internal requisite paperwork to complete the enrollment process will be done upon a provider applicant's attendance of the educational session. Failure to attend an educational session will result in non-completion of the enrollment process and a denial of provider status. Descriptions of all Provider Trainings are as follows:

1. Provider Applicant Training: This training is for provider applicants prior to their potential enrollment as Medicaid Nursing Services providers. The training was implemented after it was discovered that applicants required clarification related to program requirements and the enrollment process. Applicants are given the information prior to continuing with the application for enrollment. After learning more about the program and its requirements, some providers may choose not to continue with the application process and are referred to other Medicaid programs of interest to them.

2. New Provider Education/Training: This training is the final step for the provider applicant prior to their enrollment. This training provides information on the regulations, preauthorization, participant eligibility, etc. Upon completion of this training, the provider is enrolled as a Nursing Services provider.

3. Provider Training: This training is for enrolled providers. This training is held when the State discovers trends of varying areas of non-compliance or areas of clarification and determines that technical assistance/education is required or the State aims to inform providers about newly established procedures, regulatory amendments, and/or audit trends.

4. Provider One-to-One Training: This training was implemented in September 2015 and is also held for enrolled providers. The State’s intent is to remain proactive by offering this training to providers to inform them of best practices. As determined by the State, based on audit reviews, the State may initiate this education. Providers may also request this training for technical assistance. This training will review overall requirements and address any concerns specific to each provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DONS
Office of Health Care Quality (OHCQ)

Frequency of Verification:

Verification of current licensure is required prior to provider enrollment as well as on an annual basis; verification of Medicare certification and enrollment is required prior to enrollment.
Medicaid provider revalidation is a requirement from 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

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:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Principal Physician's Participation in the Plan of Care Meeting

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
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 principal physician is a licensed specialty physician who is part of the multidisciplinary team who prescribes home care services and signs the POC of the participant.

The Plan of Care meeting is a unique service specific to the Model Waiver. The physician's participation in the Plan of Care Meeting is routinely a 20-minute visit as compared to the average time spent in a medical appointment with a physician, 13-16 minutes. A physician visit, however, also requires additional extensive medical tasks and review of documentation---including tasks completed by auxiliary staff such as medical aides, nurses, etc. Comparatively, participation in the Plan of Care meeting requires the physician's familiarity with the regulations and policies of the waiver program, input in the development of the PCP, and review of the PCP document in collaboration with the other members of the multi-disciplinary team.

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

There are no arbitrary limits on the amount, frequency or duration of the service.

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
Individual	Physician

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Principal Physician's Participation in the Plan of Care Meeting

Provider Category:

Individual

Provider Type:

Physician

Provider Qualifications

License *(specify):*

Licensed as a physician in Maryland or the jurisdiction in which they practice

Certificate *(specify):*

Other Standard *(specify):*

Must be declared board-certified or eligible by a member board of the American Board of Medical Specialties or has been declared board-certified or eligible, by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association

Verification of Provider Qualifications

Entity Responsible for Verification:

MDH, Provider Services

Frequency of Verification:

Current licensure is required prior to provider enrollment as well as on an annual basis.
Medicaid provider revalidation is a requirement from 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

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 participants receive case management services via an enrolled Medicaid provider.

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):

(a) The State requires that agencies providing nursing and/or shift home health aide/certified nursing assistant services-certified medication technician services to waiver participants conduct a criminal investigation of individuals providing services to Medicaid clients. These positions include registered nurses, licensed practical nurses, and dually certified nurse assistants/shift home health aides-certified medicine technicians.

(b) The scope of the criminal background investigation completed for the above positions is a statewide child care criminal history background investigation completed by the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services, in accordance with family Law Article, §5-561, Annotated Code of Maryland.

(c) Verification that criminal background checks are completed occurs at 3 points:
When DONS staff reviews provider applications before approval as a Medicaid provider;
When DONS staff conducts audits of the provider agencies; and

Upon request, the DONS also mails providers a list of individuals who are prohibited from participating in Medicaid as listed on the following websites: http://exclusions.oig.hhs.gov/ and www.mbon.org (Maryland Board of Nursing).

Additionally, background check verifications are completed by the Department's Policy and Compliance Division which performs revalidations of providers in accordance with 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), which requires all state Medicaid agencies to revalidate the enrollment of all providers at least every five years.

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: 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 MW program is an open and continuous process. Providers can apply to become providers by requesting a provider enrollment packet from Medicaids Provider Enrollment Division and/or the MDH website https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx. Completed applications are returned to the DONS for review and approval or denial.

Potential providers have access to information regarding the MW including information concerning conditions for participation. Medicaid program transmittals are listed on the Maryland Department of Health's website. Copies of regulations and transmittals can also be requested from the DONS. The availability of information pertaining to the conditions for participation as a provider of waiver services as well as the existence of an open and continuous enrollment process demonstrates that all willing and qualified providers of waiver services have the opportunity to enroll as a Medicaid provider to render services to MW participants.

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:
QP1: Percent of providers who meet licensure and/or certification standards; Numerator: Total # of audited providers who meet licensure and/or certification standards; Denominator: Total # of audited providers Note: all MDCs, RSAs, HHAs are licensed provider agencies, physicians are licensed Case Managers are licensed registered nurses, there are no unlicensed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
audit:(on-site and desk)

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: 20% of enrolled nursing services provider are audited
	☐ **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: OHCQ conducts initial & on-going licensure surveys for RSAs and HHAs who provide PDN services Provider Services also conducts licensure verification during provider revalidation

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:
QP2: Percent of nursing/certified nursing assistant/home health aide providers who have completed educational training conducted by DONS staff (one or more of the following trainings: Provider Applicant, New Provider Education; Provider Training, Provider One-to-One Training); Numerator: Total # of providers who have completed training; Denominator: Total # of enrolled providers

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

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:	

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.

The DONS staff is responsible for enrolling providers to render private duty nursing and/or home health aide/certified nursing assistant services to waiver participants. The provider applicant initially submits an application to the Provider Services unit, which pends the application in MMIS and then forwards the pended application to the DONS. The DONS existing provider enrollment policy requires applicants for provider status to attend an educational session prior to completion of the provider enrollment policy. The final internal requisite paperwork to complete the enrollment process will be done upon a provider applicant's attendance of the educational session. Failure to attend an educational session will result in non-completion of the enrollment process and a denial of provider status. Descriptions of all Provider Trainings are as follows:

1. Provider Applicant Training: This training is for provider applicants prior to their potential enrollment as Medicaid Nursing Services providers. The training was implemented after it was discovered that applicants required clarification related to program requirements and the enrollment process. Applicants are given the information prior to continuing with the application for enrollment. After learning more about the program and its requirements, some providers may choose not to continue with the application process and are referred to other Medicaid programs of interest to them.

2. New Provider Education/Training: This training is the final step for the provider applicant prior to their enrollment. This training provides information on the regulations, preauthorization, participant eligibility, etc. Upon completion of this training, the provider is enrolled as a Nursing Services provider.

3. Provider Training: This training is for enrolled providers. This training is held when the State discovers trends of varying areas of non-compliance or areas of clarification and determines that technical assistance/education is required or the State aims to inform providers about newly established procedures, regulatory amendments, and/or audit trends.

4. Provider One-to-One Training: This training is also held for enrolled providers. The State's intent is to remain proactive by offering this training to providers to inform them of best practices. As determined by the State, based on audit reviews, the State may initiate this education. Providers may also request this training for technical assistance. This training will review overall requirements and address any concerns specific to each provider.

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.

Providers are notified immediately that their participation in the waiver is suspended if an audit identifies them as lacking current licensure/certification as required by regulation. The suspension is in effect until such time as verification of current licensure/certification is received by the DONS staff. Failure to submit documentation of current licensure/certification in a timely manner results in termination of the agency's provider status and recovery of monies paid during the non-compliant period.

An existing provider will be required to attend an educational/training session if the review results in the determination that it has not attended one because it was enrolled prior to the implementation of the requirement to attend the session. Provider applicants will not be enrolled until they have been oriented by attending an educational session.

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.

Case management, physician participation in the plan of care development, delegated nursing services, and private duty nursing are waiver services provided in the individual's own home or the community which is available for the public to use and visit and therefore presumed to meet the HCB Settings requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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:
- ☐ **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.

(a) The CM provides the participant, family member or representative with information regarding the MW which includes but is not limited to rights and responsibilities and service plan development during the initial meeting, at least annually and on an as-needed basis. The participant and/or his legal representative are active members of the multi-disciplinary team (MDT) which develops the participant's POC. The other members of the multi-disciplinary team consist of the participant's principal physician or the physician designated by the principal physician, the case manager and a representative of the nursing/home health aide/certified nursing assistant provider. The development of the POC is based on a comprehensive assessment which incorporates the participant's strengths, preferences, goals, desired outcomes, and needs. The POC must be signed by the participant or his family/legal representative which indicates approval of the plan. The participant and/or their representative are encouraged to be actively engaged in all aspects of the waiver process.
(b) The participant and/or his/her family or legal representative may authorize other individuals to participate in the POC process.

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):

Service Plan Development Process:
(a)The case manager with the individual, the individual's authorized representative, and the multidisciplinary team (MDT)*** collaborate in developing the initial Person-Centered (PCP) which is reviewed by the MDT and revised 90 days after the individual is enrolled in the waiver. Thereafter, a semi-annual meeting is held to revise the PCP unless the individual and MDT determine that a different review period is appropriate or the individual's needs change. The developing PCP is reviewed by the SMA's DONS Nurse Consultant prior to the meeting of the individual's MDT. The PCP is then reviewed and approved or adjusted by the individual's multidisciplinary team which includes the waiver individual, his/her legal representative, his/her principal physician or physician designated by the principal physician, case manager, and providers of health-related services as appropriate. The individual, his or her authorized representative, and family members are the central members of the team responsible for planning and developing a Person-Centered Plan. The individual, or his or her authorized representative on the individual's behalf, may invite others important to the individual to be part of the planning process. However, the individual, or his or authorized representative, also retain the authority to exclude any individual from development of his or her Person-Centered Plan with the case manager.
(b) Information used to assess the individual's needs and support the service plan development process includes hospital discharge plans, comprehensive information concerning the individual's medical history and physical information, etc. In addition, the case manager performs an in-home assessment and gathers information regarding the individual's needs, goals, and preferences from the individual, his or her family, friends, and any other individuals invited to participate in the planning process. The case manager also reviews other formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., Speech Pathologist, Occupational Therapist, Physical Therapist), as appropriate.
(c) The individual is informed of the services available to him/her under the waiver when his/her/her case manager meets with him/her and/or his/her legal representative prior to enrollment in the waiver as well as prior to or during the PCP meeting. During initial meetings and the 180-day plan development meeting, the case manager shares information with the individual and his or her authorized representative and family about available waiver services and qualified providers (e.g.., providers, community-based service agencies, and vendors). The case manager also provides information on how to access a comprehensive list of services (including all waiver-covered services) and licensed and approved providers. The case manager assists the individual in integrating the delivery of supports needed. The case manager provides the individual with a hard-copy resource brochure and provider matrix.
(d)The case manager uses an individual-directed, person-centered planning approach. This approach identifies the individual's strengths, needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for a Person-Centered Plan. As part of this person-centered planning approach, the case manager gathers information from the individual, his or her circle of support (family and friends), assessments, observations, and interviews.
Based on a person-centered planning approach, a Person-Centered plan of care is developed that identifies supports and services to meet the individual's needs, goals, and preferences in order for the individual to live in his or her home or community and whether those supports and services will be provided by natural or informal supports, other local, State, and federal programs, or this waiver program. Skills to be developed or maintained under waiver services are determined based on the individual's individualized goals and outcomes as documented in his or her PCP. The PCP will also address any need for training for the individual, his or her authorized representative or family, and provider or direct care staff in implementing the Person-Centered PCP. During his/her meeting when all team members discuss the individual's needs and preferences, the developing PCP is either modified as needed or approved as written. The approved PCP is signed by the individual or his/her legal representative, his/her principal physician, the case manager and the SMA's DONS Nurse Consultant. If the individual or his/her legal representative does not agree with the PCP as developed by the multidisciplinary team, the individual indicates his/her disagreement with the PCP via his/her signature in the appropriate area and may request a fair hearing.
(e) The case manager along with the individual and MDT ensure that waiver services, as well as other services, are coordinated when developing the PCP. The review of the developing PCP by the SMA's DONS Nurse Consultant ensures that services are proposed and coordinated according to Program regulations.
The plan is reviewed regularly after development by the MDT to continue to address the following participant goals (health, vocational, and educational), participant needs (medical history and physical information, recent hospitalizations, significant events); and participant preferences/choices (satisfaction with health care providers/services-e.g., nursing, DMS/DME, etc).
(f) The PCP development process provides for the assignment of responsibilities to implement and monitor the PCP by requiring the case manager to discuss the PCP during the requisite monthly telephone contact with the individual or his/her legal representative. Given the prevalence of utilization of nursing services in the waiver, along with the review of other services, the case manager is required to review one week of a nursing agency provider's nursing notes on a

monthly basis to ensure care is rendered in accordance with the approved PCP. The DONS staff conduct audits of provider records, as well as review MMIS paid claims data to determine whether services are delivered in accordance with the individual's PCP.
(g) The PCP is revised at least semi-annually unless the individual, the SMA's DONS Nurse Consultant, and the MDT determine that a different review period is appropriate. In addition, the individual's PCP is reviewed and, if necessary, updated when the individual's needs change. All PCP's (i.e., initial and ongoing) are reviewed by the SMA's DONS Nurse Consultant for approval.

***Multi-disciplinary Team (MDT) means the group consisting of the participant or the participant's legal representative or representatives, or all of these, home care providers, and the participant's principal physician or the physician designated by the principal physician, and other providers of health-related services, as appropriate, that establishes and updates the plan of care and assesses the appropriateness of the participant's discharge to or continuation of home care.

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.

Potential risks to an applicant and, once enrolled the participant, are assessed by his physician, the applicant/participant and/or his legal representative, and the case management provider through a review of medical documentation and a face to face assessment of the individual. Identified health and safety risks and the medical supports that are needed to support the individual safely in the community are documented in the draft POC and discussed during the multidisciplinary teams meeting. Specific strategies for dealing with each identified risk are reflected in the POC. The POC includes emergency back-up plans containing information about provider on-call systems and emergency medical care.

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.

The participant's case manager provides him/her with a list of potential Medicaid enrolled agencies. The participant and/or his family/legal guardian may independently contact agencies to request services or request the assistance of the case manager. The list is maintained by the DONS and is provided to the case management agency on a quarterly or as-needed basis.

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):

The PCP is revised at least semi-annually unless the individual, the SMA's DONS Nurse Consultant, and the MDT determine that a different review period is appropriate. In addition, the individual's PCP is reviewed and, if necessary, updated when the individual's needs change. All PCP's (i.e., initial and ongoing) are reviewed by the SMA's DONS Nurse Consultant for approval.

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:

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.

Service Plan Implementation and Monitoring:
(a) The individual's case manager is responsible for monitoring the implementation of the service plan and an individual's health, welfare and safety needs.
(b) The case manager conducts monthly telephone contacts with the individual or his legal representative and visits on a quarterly basis to ensure services are rendered in accordance with the approved POC. Audio-visual visits may be completed as authorized by the SMA program staff.
(c) The case manager is required to review one week of a nursing agency provider's nursing notes on a monthly basis to ensure care is rendered in accordance with the approved POC. The DONS staff conducts audits on a quarterly basis during which provider records and/or MMIS paid claims data are reviewed to determine whether services are delivered in accordance with the individual's approved POC.

The Division of Nursing Services (DONS) shares the overall responsibility of implementing and monitoring the service plans (POCs) of waiver participants with the case management entity. POCs are developed during the interdisciplinary meeting. Part of the development of the POC involves the implementation and back-up plans required to ensure the on-going provision of care and services based on the established plan. Case managers contact the DONS Nurse Administrator when problems with the participant's service plans arise. For example, the Nurse Consultant will assist in the resolution of an issue such as calling the nursing agency to determine the cause of a particular problem and work with the agency to see it is resolved.

The case management agency has a voice mail system which is available 24 hours per day to enable participants and/or their legal representative to advise the case manager of a development which has occurred outside normal business hours. In addition, the case manager may contact the participant's physician and, if needed, an emergency multidisciplinary POC meeting can be scheduled and held to address any status changes.

The DONS conducts an annual audit of the case management agency which includes ensuring participants exercise free choice of providers. The case management agency reviews the "freedom of choice" form with each MW participant as well as a matrix of enrolled providers from which the participant may choose. At each annual audit via the LTSS data management system, the DONS ensures that these requirements are met.

The participant’s service plan includes all services the participant receives, including waiver and non-waiver services. During each MDT meeting, services are discussed and any barriers to access are brought to the attention of the State’s MW Coordinator. The MW Coordinator and the case manager work to resolve these issues. Service plans are also reviewed during the State’s annual audit of the case management agency.

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:
SP1: Percent of waiver participants who have their assessed needs addressed in the service plan through individually chosen waiver funded services, other funding sources or natural supports. Numerator: number of waiver participants who have their assessed needs addressed in the person-centered service plan; Denominator: Number of participants reviewed.

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: Case management agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: at least semi-annually	

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:
SP2: Percent of waiver participants who have their personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports Numerator: Number of waiver participants who have their personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator: Number of participants reviewed

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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Case Management Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: at least semi-annually	

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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:
SP3: Percent of POCs reviewed by the MDT and signed by all participants of the MDT and MW Coordinator; Numerator: Total # of POCs reviewed by multi-disciplinary team (MDT)that were completed in accordance with established policies and procedures; Denominator: Total # of participants

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

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: as needed, at least annually	

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:
SP5: Percent of POCs evaluated every 12 months; Numerator: Total # of POCs evaluated every 12 months; Denominator: Total # of waiver participants

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
and the participant POC

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:
SP4: Percent of updated POCs; Numerator: Total # of updated POCs; Denominator: Total # of waiver participants whose needs change during the 12-month cycle

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
and participant POC

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:
SP6: Percent of participants with services delivered in accordance with the amount, duration and frequency of the service specified in the plan of care ; Numerator: Total # of participants with services delivered in accordance with POC; Denominator: Total # of sampled participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
participants' POC and MMIS

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: random sampling total of 40%
	☐ **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:

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:
SP7: Percentage of records that contain signed Parents Rights & Responsibilities form indicating individual or family a choice of waiver services and providers. Numerator: # of records containing a signed Parents Rights and Responsibilities form; Denominator: # of waiver participant records reviewed. Note: All participants are given provider lists and may choose between service providers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
In addition to off-site records, OHS reviews records on-site on an annual basis.

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:

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 DONS performs an annual random sample review of waiver participants' records maintained by the case management agency via the LTSS data management system, which will document any missing items such as a current POC, LOC determination, signed Freedom of Choice form, etc.

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.

The DONS Nurse Administrator provides oversight of planning activities and ensures the case management provider's compliance.
DONS staff provides technical assistance and support on an ongoing basis to case management providers and provide specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in-person meeting, and training.
Remediation efforts will be documented in the provider’s file with the DONS.

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 to individuals who are denied the choice of HCBS waiver services as an alternative to institutionalization, 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 Fair Hearings will be granted to individuals who are aggrieved by any Department policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. Each waiver participant and/or his/her legal representative is provided a copy of the notice of Fair Hearing whenever a specific service is denied or reduced and at each POC meeting.

The waiver participant is notified in writing of all denial or reduction of services and apprised of his right to request a Fair Hearing within 90 days. In addition, the written notice advises the individual that services will be continued during the appeal process if the aggrieved action is appealed within the 10-day continuation of benefit period. Participants and/or their representatives may receive assistance applying for a fair hearing if requested from a provider or their case manager. Information is in the packet that is sent to the participant and/or representative regarding the adverse action, the Summary of Procedures for a Fair Hearing reflects contact information related to Legal Aid and Disability Rights Maryland (formerly Maryland Disability Law Center). This document also informs the participant that additional information can be submitted and will be reviewed before the hearing if the participant requests a reconsideration. This information is explained and reviewed with the participant during the multidisciplinary team meeting process as well.

Applicants and waiver participants are advised of their right to request a fair hearing by the following entities:

The Utilization Control Agent (UCA) when a qualifying LOC is denied;
MDH when waiver or State Plan services are denied, reduced, or terminated; and
MDH when an applicant is denied waiver eligibility.

The Office of Long Term Services and Supports (OLTSS) maintains a database specifically related to appeals and scheduled hearings. In addition, the DONS maintains this information in the participant's individual file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

system:

The Maryland Department of Health (MDH) is the State-designated Medicaid agency. The Office of Long Term Services and Supports (OLTSS) maintains oversight of day to day issues and activities related to the Model Waiver and is responsible for the operation of the grievance/complaint system.

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 service and quality of care complaints related to waiver participants.
(a) A complaint is defined as any communication, oral or written, from a participant, participant's representative, provider, or other interested party received by staff of the Office of Long Term Services and Support (OLTSS). Administrative, service related and quality of care complaints are reviewed by staff.
(b) The process for addressing grievances/complaints is the OLTSS Reportable Event Policy. Timelines for addressing complaints are as follows: 24 hours for emergency medically related as well as abuse, neglect and exploitation complaints, 5 days for non-emergency medically related complaints and 45 days for administrative complaints.
(c) Numerous methods are used to resolve complaints. The case manager is the person most often involved in addressing a complaint. Examples of some interventions utilized are:
Discussion between the case manager and the participant, his legal representative and his physician (if necessary).
Providing the participant and/or his legal representative with a list of alternative providers and assisting them in the process of obtaining a new provider.
Recommendation to change the participant's POC.
Assist the family with seeking alternative funding sources for services and/or items not covered under Medicaid's State Plan and the waiver.
Advising the participant or his legal representative to file a request for a Fair Hearing if the complaint or grievance involves a reduction, denial, or termination of service;***
If the complaint is regarding a waiver provider, the DONS works with the provider to resolve the issue if the participant wishes to continue to receive services from the provider if appropriate.
Referrals are made to other jurisdictional agencies including but not limited to the Maryland Board of Nursing for nursing certification/licensure issues and the Office of Health Care Quality when there are provider licensure violations or complaints.

*** The case manager advises the participant of his/her option to file a grievance or make a complaint as well as the option to request a Fair Hearing. The participant is informed that a complaint or grievance does not replace a Fair Hearing request. The participant is given separate instructions for requesting a Fair Hearing which includes the required time frames for submitting requests.

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).

Reportable or critical events are defined as the allegation of or an actual occurrence of an incident that may pose an immediate and/or serious risk to the physical or mental health, safety, or well-being of a waiver participant or complaints regarding an administrative service or quality of care issue as follows:

- Incidents:
- Abandonment
- Abuse: physical, sexual, verbal or emotional
- Accidents or injuries requiring treatment beyond first aid
- Death: anticipated or unanticipated
- Emergency room treatment
- Exploitation: theft, financial
- Hospitalization: anticipated, unanticipated, psychiatric or behavioral
- Missing person
- Neglect and self-neglect: nutritional, medical, environmental, physical
- Treatment error: medication or delegated task
- Rights violation
- Infectious disease
- Any other event that might impact the participant's health and safety
-
- Complaints:
- Access/service
- Communication issue
- Delays
- Professionalism (e.g., tardiness, inappropriate cell phone use, etc.)
- Other

The case management provider completes and submits a reportable event form and forwards it the Nurse Consultant for the MW within the DONS. The Nurse Consultant is also notified by telephone of problems that are serious as specified in the reportable event policy (i.e., those categorized as "immediate jeopardy") within 24 hours. Nurses and certified nursing assistants/home health aides licensed by the Maryland Board of Nursing must report all instances of abuse and neglect to local law enforcement and/or the local social service office as required by Maryland's Health Occupation Article, Title 8, Section 8-16(a)(13). They are informed of this legal requirement during their course of study for their respective field. In addition, the case manager must report all instances of abuse and neglect to local law enforcement and/or the local social service office within 24 hours. All reportable events are closely monitored until the case is closed.

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

Case managers meet with all applicants and or their legal representatives prior to admission to the MW and explain the process for reporting any issues that may arise. MW providers are instructed during their educational session prior to their enrollment as a MW provider, at annual trainings, and with the DONS during one-to-one technical assistance meetings. Interested parties are also given the telephone number for DONS so that they may reach a responsible party at MDH to discuss issues and/or receive information and assistance. Reporting requirements and training are also re-enforced at least annually with the participant and family by the case manager.

Repeat training is provided to these groups, particularly providers, when it is found that a provider failed to adhere to the proper procedures.

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.

Reports of incidents are received by the case management agency as well as the DONS. The case management agency relays any reportable events and information it receives to the Nurse Consultant within the DONS. Investigations are conducted either at the case management level or by DONS depending on the issues and severity of the situation.

Situations categorized as immediate jeopardy involving actual or potential alleged abuse, neglect or exploitation must be reported to an Adult Protective Services (APS) or Child Protective Services (CPS) office within 24 hours. An investigation by the CM and DONS is initiated within 2 working days of the referral. A follow-up action plan must be completed within 7 calendar days of receipt of the original reportable event. All reportable events are closely monitored until the case is closed.

Processes involve verbal and/or written communications from individuals, individuals' representatives, providers and case managers. Communication of reportable events are made to supervisors at the case management agency, the Nurse Consultant at the DONS and, if necessary, to supervisors within the DONS. Reportable events concerning the denial of requested services and appeal of same will involve the State Attorney General's Office and the Office of Administrative Hearings. Reportable events concerning quality of care issues involving licensed nursing agencies will also be reviewed and addressed by the Office of Health Care Quality and where applicable sent to other agencies such as the Maryland Board of Nursing. When there is a complaint, a telephone communication and/or written letter is sent to the participant and/or the representative upon completion of the review and/or investigation as requested by the participant/representative. This should occur within 10 business days of the resolution.

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 DONS is responsible for the oversight of the incident reports. Reportable events are immediately reviewed upon receipt by the Nurse Consultant for the MW who, depending on the situation, engages in discussion with case managers, providers, waiver participants or their legal guardians to coordinate efforts to resolve problems. Reportable events are compiled and forwarded to the Nurse Consultant by the case management agency as they are received. If the Nurse Consultant is contacted directly, efforts at investigation and resolution are initiated immediately to address the issue and prevent reoccurrence or further problems. Oversight is conducted by the DONS Nurse Consultant on a regular, daily basis. The reportable event data is reviewed and analyzed, changes may be made to systems and/or processes based on the analysis. If there are specific issues with a provider, the provider is mandated to repeat the education/training session which was also required prior to enrollment. Systemically, transmittals and/or educational alerts are distributed to providers when applicable. Medicaid can implement other measures if providers fail to take appropriate actions to address the event, etc.

OHCQ also oversees the licensed agencies and conducts surveys/investigations. When problems are identified, OHCQ staff may request a plan of correction for non-compliance including reportable events that are not appropriately addressed by the provider to prevent reoccurrence. There are other remedies that OHCQ can impose when providers have continued non-compliance. OHCQ may also make referrals to the Maryland Board of Nursing, as appropriate.

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:

Waiver participants reside in their homes. The case managers, however, conduct on-site visits to the participant's home and the nursing personnel who provide services to the participant, provide that service in the home. Case managers and nursing staff are required to report the unauthorized use of restraints or seclusion to the OLTSS via the Reportable Event policy and protocol. Case managers visit the participant at least quarterly and maintain phone contact on a monthly basis, and the nursing personnel routinely render care to the participant on a daily basis (the majority of nursing services participants receive services 4 or more days per week). Many of the participants attend school and are monitored closely while at school. School personnel are also required to report restraint use per their individual district policies.

○ **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).

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:

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:

Waiver participants reside in their homes. The case manager visits the participant in the home and the nursing personnel provide services to the participant in the home are required to report the unauthorized use of restraints or seclusion to the OLTSS via the Reportable Event policy and protocol. Case managers complete a face-to-face and/or audio visual visit at least quarterly and are required to conduct monthly phone contacts. Nursing personnel generally are in the home on a daily basis (the majority of nursing services participants receive services 4 or more days per week). Many participants attend school and school personnel are required to report the unauthorized use of restraints based on their policies and procedures.

○ **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.

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:

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:

Waiver participants reside in their homes. The case manager visits the participant in the home and the nursing personnel provide services to the participant in the home are required to report the unauthorized use of restraints or seclusion to the OLTSS via the Reportable Event policy and protocol. Case managers complete a face-to-face and/or audio visual visit at least quarterly and are required to conduct monthly phone contacts. Nursing personnel generally are in the home 4 or more days per week for those participants receiving nursing services. Many participants attend school and school personnel are required to report the unauthorized use of restraints based on their policies and procedures.

○ **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.

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.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

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

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

○ **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.

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:
HW6: Percentage of providers that complete incident management training.
Numerator: Number of providers that complete incident management training.
Denominator: Number of providers (case management and nursing services providers).

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:

Performance Measure:
HW5: Percentage of confirmed critical incidents of abuse, neglect, exploitation & unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. Numerator: # of confirmed incidents of abuse, neglect, exploitation & unexplained death for which corrective actions executed or planned by appropriate entity in required time frame Denominator: # reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

collection/generation *(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: Case Management Agency	☐ **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:

Performance Measure:
HW1: Percentage of reportable events (RE) involving abuse, neglect and/or exploitation; Numerator: Total # of reported and investigated REs involving abuse, neglect and/or exploitation; Denominator: Total# of all incidents reported

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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: Case management agency	☐ **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:
HW3: Number and percent of case management providers that receive annual training in identifying, addressing, and preventing abuse, neglect, exploitation, and unexplained death. N = # of case management providers that received annual training in identifying, addressing, and preventing abuse, neglect, exploitation, and unexplained death/ D = # of case management providers.

Data Source (Select one):
Program logs
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:
HW2: Percentage of reportable events involving unexplained or suspicious deaths; Numerator: The number of reported events involving unexplained or suspicious deaths; Denominator: Total number of deaths

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**

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:
HW4: Percentage of reportable events substantiated as instances of abuse, neglect, and/or exploitation Numerator: Total number of reported events that were substantiated as instances of abuse, neglect, or exploitation; Denominator: Number of investigations of incidents of potential abuse, neglect, or exploitation.

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:

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:
HW7: Percentage of incidents reported/investigated within the required timeline;
Numerator: Total # of incidents reported and investigated within required timelines;
Denominator: Total # of all incidents reported

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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: Case Management Agency	☐ **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:
HW8: Percentage of participants who received education on how to report the reportable incidents and complaints at enrollment; Numerator- number of participants who received education on how to report the reportable incidents and complaints at enrollment; Denominator- total number of participants enrolled in waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual audit of case management agency

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: Case Management Agency	☒ **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:
HW9: Percentage of substantiated incidents involving restrictive interventions (prohibited use of restraints or seclusion); Numerator: Number of reported incidents of restrictive interventions that were not substantiated; Denominator: number of reported incidents

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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: Case Management Agency	☐ **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:
HW10: Percentage of waiver participants who express satisfaction with the quality of services provided; Numerator: # of waiver participants who express satisfaction with the quality of services provided Denominator: # of waiver participants who completed a satisfaction survey

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

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: Case Management Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: N/A	

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: Case Management Agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 identifies problems within the waiver via the Reportable Event process and policy as well as through information provided via the participant's case managers and nursing services providers. The case managers and providers often call the Nurse Consultant immediately upon discovery of a waiver problem/issue (i.e. within 24 hours). The phone call is then followed by the submission of a completed Reportable Event form.

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.

Individual problems will be addressed and resolved in conformance with the Reportable Event Policy. Involved parties may include the DONS Nurse Consultant, the participant and/or his legal representative, the case manager, entities such as Child Protective Services (CPS), Adult Protective Services (APS), the Maryland Board of Nursing, Maryland Department of Human Services, the police department, a provider agency, etc. General methods for problem correction may include such actions as conference calls, meetings, etc. which may result in such actions as a change in the provider agency or the participants residence, training, or require a Corrective Action Plan from the service provider. The State documents such events via the Reportable Event Policy form.

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: semi-annually

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.

The analysis of discovery data and remediation information is conducted on an on-going basis due to the design feature of regular reporting and communications among waiver partners and stakeholders, as well as the Model Waiver Advisory Committee. OLTSS is the lead entity responsible for trending, prioritizing and determining system improvements. 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 the licensing office, case management providers, participants/families, and Waiver Advisory Committee members.

When data analysis reveals the need for system change, DONS staff make recommendations to OLTSS management and discuss the prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders primarily through the forum of the Model Waiver Advisory Committee. The purpose and objective of the MW Advisory Committee is to provide feedback for regulation amendments and new initiatives to improve quality and the delivery of services as well as the satisfaction of participants with their services. Membership includes but is not limited to providers, Medicaid waiver staff, primary care physicians, participants and family members. Meetings are quarterly and customer satisfaction surveys are presented annually. The Committee also reviews the results of the 372 and the Evidence Report.

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: Model Waiver Advisory Committee	☐ **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.

Monitoring the effectiveness of system design changes is an on-going process performed predominantly by the OLTSS staff who are responsible for the administration of the waiver and for ensuring an effective, dynamic quality management plan. Stakeholders also have a definite role in providing input to OLTSS regarding plans for system design changes. As a logical extension of that role, stakeholders would also be involved in analyzing the results of changes made to the design of the Model Waiver. These processes will be central to the guiding purpose of the Model Waiver Advisory Committee. Again, waiver design changes will always be presented to the Waiver Advisory Committee for input and direction as appropriate and will be shared with participants and families through mailings and as part of the annual satisfaction survey.

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

The quality improvement strategy or what is referred to in this application as the quality management plan is subject to continuous evaluation of effectiveness and relevance by participants, providers, other stakeholders and administering waiver staff. The quality management plan is based on decisions made by OLTSS and its waiver partners about the types of data that will be gathered, the performance measures which will be established, the parties that will analyze data and evaluate system changes and at what frequency. Through the continuous process of discovery, vital information will continually flow into the waiver from many sources, such as, Reportable Events, waiver performance measures, Model Waiver Advisory Committee meetings, provider reviews by DONS' staff, provider licensure and complaint surveys/reports, consumer satisfaction surveys, Maryland Board of Nursing data, provider input, Fair Hearings and provider audits. If the quality management plan is not working as it should be, the repetition of issues and problems and unsuccessful remediation actions will indicate that the quality management plan must be evaluated. To provide structure to the periodic evaluation of the quality management, OLTSS staff will routinely involve the Model Waiver Advisory Committee. 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 who are not current members of the Model Waiver Advisory Committee.

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):*

The survey is completed annually. Participants are requested to rate their responses to each statement using one of the five scale Likert measurements (Very Satisfied, Satisfied, Neutral, Dissatisfied, and Very Dissatisfied). Survey statements measure the satisfaction related to the services covered by the Model Waiver program and satisfaction with multidisciplinary meetings.

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 Marylands Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Marylands Comptrollers Office. The present contractor is Abrams, Foster, Nole and Williams.

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.

DONS:
The DONS reviews paid claims for services authorized for MW clients and, when necessary, recovers inappropriate payments identified as a result of the review. In addition, DONS staff conducts desk as well as on-site audits of providers to monitor paid claims and to recover funds as necessary. If there appear to be substantial issues with the providers Medicaid billing, the DONS refers the provider to the Office of Inspector General for a more detailed audit. Such actions have led to referrals to the Medicaid Fraud Control Unit of the Attorney General's Office for further investigation and criminal prosecution.

The DONS conducts quarterly reviews of nursing services paid claims for MW participants. A random sample of 10% of MW participants that received nursing services are selected for a quarterly claims review. A claims report for MW participants is generated from the Medicaid Management Information System-II quarterly. The purpose of the quarterly claims review is to ensure that providers are appropriately billing in accordance with the current and authorized plan of care.

The circumstances that dictate whether a desk or on-site audit is completed vary. Circumstances for on-site audits may be based on the amount of documentation necessary for review (e.g. a high volume of documentation) or if an unannounced visit is required in response to a complaint.

If an action is initiated requesting that a provider reimburse the State for inappropriate payments, the DONS sends a letter to the provider that includes a summary of the action with regulatory citations of the non-compliance that generated the recovery action. Providers have thirty days to appeal the decision, requesting an administrative hearing. If no hearing is requested or the administrative hearing decision upholds the recovery then monies can be reimbursed by direct payment by the provider or recoupment of future payments made to the provider. Providers may also request payment arrangements with the Department to reimburse the State.

The State recoups payments for inappropriate billings via post-payment reviews. Recoveries for inappropriate claims are processed through MMIS where both the state and federal share are recognized. A recovery made in the aforementioned manner is netted against the weekly draw of federal match, in the same week recovered. The FFP for the inappropriate claim is returned in the weekly draw process as a netted transaction.

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:
FA1: Number and percentage of claims that are coded and paid for with the reimbursement methodology for the service; Numerator: Total # of claims identified as paid in accordance with the reimbursement methodology for the service; Denominator: Total # of claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS and the POC of participants

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:*

		10% of MW nursing services participants per quarter
	☐ ***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 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:

FA2: Percentage of provider payment rates that are consistent with the rate methodology
Numerator: Number of provider rates consistent with the rate methodology.
Denominator: Number of provider rates reviewed annually.

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***

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

OLTSS routinely conducts audits and reviews paid claims in MMIS to discover/identify problems/issues within the waiver. These activities are conducted on an annual basis.

The DONS conducts quarterly reviews of nursing services paid claims for MW participants. A claims report for MW participants is generated from the Medicaid Management Information System-II quarterly. The purpose of the quarterly claims review is to ensure that providers are appropriately billing in accordance with the current and authorized plan of care. Each quarter the State reviews 20 percent of the total 55-65 active and enrolled nursing services providers. The selection is random and the provider is removed from the sample unless there is a complaint or reported event requiring investigation.

The circumstances that dictate whether a desk or on-site audit is completed vary. Circumstances for on-site audits may be based on the amount of documentation necessary for review (e.g. a high volume of documentation) or if an unannounced visit is required in response to a complaint.

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.*

The State routinely initiates a recovery of monies paid for services billed in excess of the participants authorized POC. Agencies found to routinely err in billing Medicaid for waiver services are offered technical assistance and are required to submit a corrective action plan. An agency which continues to consistently bill the Program inappropriately after technical assistance and a corrective action plan is received by OHS is referred to the MDH Office of Inspector General (OIG) for further investigation or terminated. Please note that the OIG makes referrals to the Medicaid Fraud Control Unit (MFCU) as necessary.

If the DONS requests that a provider implement a plan of correction due to an issue found during the completion of audit/investigation, the provider is given a due date to implement the plan. The DONS conducts follow-up reviews to ensure providers are maintaining compliance in the area that required a plan of correction. The DONS will also review if the plan of
correction is followed when the provider is due their next audit to be completed or if a significant event occurs that requires an investigation.

If the DONS discovers an issue with a provider that is beyond staff's capability to complete an investigation, the DONS will refer the case to the Department's Office of Inspector General (OIG). The OIG determines if the case should be referred to the Medicaid Fraud Control Unit (MFCU).

DONS staff reviews a listing of sanctioned providers maintained on the Department's and the OIG exclusions database. The DONS reviews these lists during the processing of new provider applicants attempting to be enrolled as Medicaid providers of nursing services and as part of audits of current enrolled providers. The Department's Policy and Compliance Division which performs validations and revalidations of providers in accordance with 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), also reviews these lists when completing validation and revalidation enrollments.

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 providers for private duty nursing and home health aide/certified nursing assistant services are paid the same rate as that paid to private duty nursing providers under the State Plan. The legislature determines indexing applied to the base rate established at the implementation of the waiver. The rate paid to these providers are increased with an inflationary factor built into the rate structure to allow routine increases (subject to the limitations of the State budget) to the rates. Proposed regulatory amendments are published in the Maryland Register and all interested parties are encouraged to submit comments on the proposed changes. The fee schedule for these services is adjusted annually in accordance with the State budget by adjusting the fee by the percentage of the annual increase in the July Consumer Price Index for all Urban Consumers, Medical Care Component, Washington-Baltimore, from the U.S. Department of labor, Bureaus of Labor Statistics.

The DONS issues a transmittal to providers notifying them of changes in payment rates.

Waiver participants may receive information concerning payment rates by requesting the information from their case manager or by calling the DONS Nurse Consultant.

Effective July 1, 2022, the Maryland Medical Assistance Program increased the rates for certain program services rendered to Medicaid participants under Code of Maryland Regulations (COMAR) 10.09.27 by 12 percent. This rate increase is inclusive of the statutory rate increase for Fiscal Year 2023 and an additional increase pursuant to Senate Bill 290, Fiscal Year 2023 Budget and the Governor's supplemental budget. This rate increase also includes a temporary four percent increase authorized by the American Rescue Plan Act, which was applied to certain home and community-based services for Fiscal Year 2023 only. The URL for the most recent fee schedule is https://health.maryland.gov/mmcp/MCOupdates/Pages/FY23-Transmittals.aspx.

When a rate adjustment is proposed other than in accordance with these provisions related to the annual increase in the July Consumer Price Index for all Urban Consumers, Medical Care Component, Washington-Baltimore (subject to the limitations of the State budget) an amendment to the regulations would be initiated by the SMA with review and input by the Model Waiver Advisory Committee. It would be submitted to the Joint Committee on Administrative, Executive and Legislative Review for approval to be published in the Maryland Register for public comment. After responding to any comments received and, if necessary, making any appropriate revisions, a notice of final action is published in the Maryland Register, after which the changes are adopted.

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:*

Providers of services to waiver participants forward bills directly to the State's MMIS claims payment system.

Invoices become a claim when a provider submits a claim for a day of service on the appropriate paper invoice or via electronic submission to the Medicaid Management Information Subsystem (MMIS). Invoices must include the following information:

- *Recipient Name*
- *Recipient MA#*
- *Provider Name*
- *Provider MA#*
- *Date of Service*
- *Pre-authorization Number*
- *Procedure Code (Service rendered)*
- *# of Units**
- *Total of Claim for date of service**

**Total claim amount for the date of service is determined by the approved/authorized Plan of Care (#hours/units authorized multiplied by the current rate for the service)*

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:*

(a) Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claims are subject to the full edits of the MMIS in addition to editing each claim to validate the participant's waiver eligibility on the date of service. The claims are also edited to ensure that those which require pre-authorization are, indeed, pre-authorized and are being billed according to the specific pre-authorization parameters such as the pre-authorization time span, the number of units of service pre-authorized, type of service pre-authorized, etc. Provider invoices must include the preauthorization number associated with the service authorized. Preauthorization numbers are generated by MMIS when DONS staff enters the authorized service (procedure code), Plan of Care (number of hours/units) and the dates of service. The provider cannot bill without the preauthorization number that corresponds to the service and dates of service/period authorized.
(b) The MW case manager validates during the quarterly participant site visit that the participant is receiving the services indicated in the plan of care by interviewing the participant and also reviews a week of nursing notes on a monthly basis. The DONS staff also verify the service was included and rendered in accordance with the participant's approved POC when it performs provider audits (on-site and desk reviews) including a review of paid claims data.
(c) The same processes as noted in (b) of this answer apply to (c) as well. In addition, providers of home health aide/certified nursing assistant and private duty nursing services must maintain sufficient documentation verifying the participants receipt of services as documented by the participant's signature or the signature of the participants witness on the providers official form.
(d) When the DONS staff completes audits, claims reviews, staff requests the nurses' notes and timesheets of the participant to review to verify that services were rendered. Timesheets must be signed by the participant's parent/representative to confirm receipt of services.

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 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:

Appendix I: Financial Accountability

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):*

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

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

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:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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	*15364.20*	*100182.00*	*115546.20*	*281648.00*	*128278.00*	*409926.00*	*294379.80*
2	*15856.88*	*101183.00*	*117039.88*	*296857.00*	*135205.00*	*432062.00*	*315022.12*
3	*16359.74*	*102195.00*	*118554.74*	*312887.00*	*142506.00*	*455393.00*	*336838.26*
4	*16872.13*	*103217.00*	*120089.13*	*329783.00*	*150202.00*	*479985.00*	*359895.87*
5	*17415.91*	*104249.00*	*121664.91*	*347591.00*	*158313.00*	*505904.00*	*384239.09*

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:	*Level of Care:*
		Hospital	*Nursing Facility*
Year 1	*220*	*30*	*190*
Year 2	*220*	*30*	*190*
Year 3	*220*	*30*	*190*
Year 4	*220*	*30*	*190*
Year 5	*220*	*30*	*190*

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.*

Model Waiver data were analyzed for FY 2017-2021 and an average length of stay weighted by level of care (nursing facility or chronic hospital) was 343 days. There was little variation in this number over the three years, so 343 days is used as the estimated length of stay for the 5 years of the renewal.

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 Medicaid Management Information System (MMIS2) was used to generate the annual Model Waiver CMS 372 Lag Reports for (FY) 2017 to FY 2022, and to generate monthly and quarterly service utilization and expenditure data. These data were used as the basis for the FY 2024 to FY 2028 waiver estimates. For the purposes of this analysis, FY 2022 is estimated based on actual claims processed to date.
In each waiver year, the waiver will serve a total of 220 participants. Model Waiver participants are assessed and categorized medically as having a chronic hospital (CH) level of care (LOC) or nursing facility (NF) LOC. Participant levels of care are used as a weighting factor in the cost-neutrality estimates. Waiver participants under the age of 21—the largest age group—are assigned a CH LOC and participants aged 21 and over are assigned a NF LOC.

To estimate Factor D, using the 372 Reports (FY 2017–FY 2021), a claims cost trends method was used to calculate an annual unit cost trend factor and an annual utilization trend factor. Claims costs trends are typically calculated as an annualized amount and the trend is compounded over time. The unit cost is the total waiver expenditures divided by the total number of service units. The annualized unit cost trend factor is the average of the percentage change in the costs of waiver services used per year. The utilization trend is the total number of service units used divided by the total number of unique service users. While the annualized utilization trend factor is the average of percentage change in the units of a waiver service used per year.
The individual unit cost trends from FY 2017 to FY 2021 were averaged to obtain the overall annualized unit cost trend factor. The same was done to obtain the overall annualized utilization trend factor. The overall annualized unit cost trend and the annualized utilization trend factors were multiplied to obtain the overall annualized combined unit cost/utilization trend factor (3.17%). The overall annualized combined unit cost/utilization trend factor incorporates actual changes in trends over time as well as prospective changes in Medicaid fee schedules. Further, the blended FY 2020 and FY 2021 utilization and cost data were used to calculate the base year upon which the estimates are based. Combining the FY 2020 and FY 2021 data will address potential variations in service use resulting from the implementation of the COVID-19 public health emergency (PHE). The overall annualized combined trend factor was then applied to the blended FY 2020 and FY 2021 (base year) per capita cost and inflated annually thereafter to estimate Factor D for WY 1 to WY 5.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' was estimated using the same method as Factor D above. Using the 372 Report data, Hilltop calculated an annual unit cost trend factor and an annual utilization trend factor for the non-waiver services. The four-year average of the annual unit cost trend factor and the annual utilization trend factor were then multiplied to obtain the overall combined trend factor (1.00%) for the non-waiver services. Hilltop then blended the FY 2020 and FY 2021 non-waiver service utilization and cost data to calculate the base year Factor D'. The non-waiver services blended FY 2020/FY 2021 per capita cost was inflated annually by the overall combined trend factor to generate the WY1 to WY 5. Estimates of Factor D' do not include the costs of prescribed medications furnished to Medicare/Medicaid dual-eligible beneficiaries.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G and G' FY 2024 to FY 2028 estimates were calculated using the FY 2018 to FY 2022 Maryland Medicaid-paid CH and NF claims. The age of the Model Waiver participants was used as proxies for LOC when weighting the annual per capita expenditures. The percentage of waiver participants under the age of 21 as of June 30, 2022, are assigned a CH LOC, and those aged 21 and older as of this date are assigned a NF LOC.

Factor G calculations require the following components:

CH LOC% = annual number of waiver participants under the age of 21/the annual number of waiver participants.
NF LOC% = annual number of waiver participants aged 21 and over/ the annual number of waiver participants
*CH_G = CH%*average annual cost per person of Medicaid-paid CH institutional costs*
*NF_G =NF%*average annual cost per person of Medicaid-paid nursing facility institutional costs*

Using the MMIS2 FY 2018 to FY 2022 chronic hospital claims, the 'service begin' and 'service end' dates were used to identify unique CH users with more than 100 CH days in each of the fiscal years. For those residents with more than 100 CH days, the number of days were summed and then divided by the number of CH residents to produce an annual average number of CH days per person. The total institutional cost associated with those CH days was also divided by the number of CH residents to obtain the average annual CH institutional cost per person for residents with more than 100 days in a CH. The FY 2022 CH average cost per person and the average number of CH days from FY 2018 to FY 2022 were multiplied to obtain the CH Factor G cost. This figure was then weighted by the percentage of Model Waiver participants with a CH LOC (93.81%) to obtain the weighted FY 2022 CH per capita expenditures. The use of participant days reduces the impact of participants with an inordinate number of institutional days in a given fiscal year.

To obtain NF Factor G, institutional costs were pulled for all the Maryland Medicaid-paid NF claims from FY 2018 to FY 2022. In each fiscal year, for those residents where the total number of NF days was greater than 100 days, their NF total institutional costs, were summed and divided by the number of NF residents in that fiscal year to obtain the annual average cost per person. The FY 2022 NF per capita expenditures were then weighted by the percentage of Model Waiver participants with a NF LOC (6.19%) to obtain the weighted FY 2022 NF FY 2022 per capital expenditures. The weighted FY 2022 CH per capita expenditures and the weighted FY 2022 NF per capita expenditures were summed to provide the overall weighted G. Factor G was then inflated annually from WY 1 to Waiver 5 by a CPI-U of 5.4%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' calculations require the following calculations:

*CH_G'= CH%*average cost per person of non-institutional services used by Medicaid-paid chronic hospital residents*
*NF_G'= NF%*average cost per person of non-institutional services used by Medicaid-paid nursing facility residents*
The CH Factor G' and NF Factor G' both utilize the same data as used to calculate Factor G. To obtain CH Factor G', FY 2018 to FY 2022 non-institutional costs were pulled from the CH claims. The number of CH days billed for each resident in each fiscal year were calculated using the begin and end dates of stays. In each fiscal year, for those residents with greater than 100 CH days, their number of days were summed and then divided by that fiscal year's number of CH residents to produce an annual average number of CH days per person. The total non-institutional cost of the CH days was also divided by the number of CH residents to obtain the average annual non-institutional cost per day of participants with more than 100 days in a CH. The FY 2022 average cost per day and the average annual number of CH days per person in FY 2018 to FY 2022 were multiplied to obtain the CH Factor G'. This figure was then weighted by the percentage of Model Waiver participants with a CH LOC (93.81%) to obtain a weighted FY 2022 CH LOC Factor G'. The NF Factor G was calculated in the same manner (calculating days, weighing the average cost, etc.,) using the 2018 to FY 2022 NF non-institutional costs. Finally, the weighted FY 2022 CH Factor G' and the weighted FY 2022 NF LOC Factor G' were summed to produce the base year Factor G'. The FY 2022 base year Factor G' was inflated annually by the All Urban Consumer Price Index for Medical Care-U of 5.4%.

Service Utilization

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 using the blended FY 2020 to FY 2021 service utilization data. Hilltop applied this percentage of unduplicated users for each service to the estimated annual number of unduplicated waiver year participants to determine the unduplicated number of participants for each Model Waiver service in each waiver year.
To estimate waiver costs and units of service, we used the actual blended FY 2020 to FY 2021 user counts, total units, units per person, cost per unit, and total costs for each service. In WY 1 to WY 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 waiver year cost for each service. Service totals were summed and divided by the estimated number of waiver participants to obtain Factor D. This Factor D should be the same or similar to the Factor D obtained above. Two nursing services (certified nursing assistant or home health aide with one participant (T1004) and certified nursing assistant or home health aide with two or more participants (T1004TT) will be removed from the Model Waiver and were therefore excluded from the individual service level estimates. Additionally, there are five state plan nursing services for which there has been no utilization since the last approved waiver application. The CMS system does not accept zeroes as acceptable values for estimates service units or service users. Therefore, to not overestimate Factor D, these services will be trended forward using minimal service users and minimal expenditures in each of the five waiver years.

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	
Case Management	
Medical Day Care	
Private duty nursing service	
Principal Physician's Participation in the Plan of Care Meeting	

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*
Case Management Total:						***1541143.15***
Waiver Enrollment Administration	*1 month*	*21*	*2.06*	*1187.99*	***51392.45***	
Second & Any Subsequent Month	*1 month*	*212*	*11.81*	*593.99*	***1487184.64***	
First Month Waiver Enrollment Administration	*1 month*	*2*	*1.08*	*1187.99*	***2566.06***	
Medical Day Care Total:						***16911.38***
Medical Day Care	*1 day*	*1*	*160.48*	*105.38*	***16911.38***	
Private duty nursing service Total:						***1820502.20***
Nurse Assessment	*1 assessment*	*1*	*3.24*	*150.81*	***488.62***	
RN Shared Services	*15 minutes*	*1*	*4.00*	*12.39*	***49.56***	
RN Supervisory Visit	*1 visit*	*8*	*7.90*	*71.80*	***4537.76***	
LPN Shared Services	*15 minutes*	*1*	*4.00*	*8.03*	***32.12***	
RN Services	*15 minutes*	*1*	*4.00*	*17.97*	***71.88***	
LPN Services	*15 minutes*	*11*	*14177.45*	*11.64*	***1815280.70***	
CNA/HHA-CMT	*15 minutes*	*1*	*4.00*	*6.15*	***24.60***	
CNA/HHA-CMT Shared	*15 minutes*	*1*	*4.00*	*4.24*	***16.96***	
Principal Physician's Participation in the Plan of Care Meeting Total:						***1566.91***
Principal Physician's Participation in the Plan of Care Meeting	*1 meeting*	*26*	*1.48*	*40.72*	***1566.91***	
				GRAND TOTAL:		***3380123.64***
				Total Estimated Unduplicated Participants:		***220***
				Factor D (Divide total by number of participants):		***15364.20***
				Average Length of Stay on the Waiver:		*343*

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*
Case Management Total:						***1590045.47***
Waiver Enrollment Administration	*1 month*	*21*	*2.11*	*1194.41*	***52924.31***	
Second & Any Subsequent Month	*1 month*	*212*	*12.12*	*597.20*	***1534469.57***	
First Month Waiver Enrollment Administration	*1 month*	*2*	*1.11*	*1194.41*	***2651.59***	
Medical Day Care Total:						***17448.91***
Medical Day Care	*1 day*	*1*	*164.69*	*105.95*	***17448.91***	
Private duty nursing service Total:						***1879411.62***
Nurse Assessment	*1 assessment*	*1*	*3.33*	*151.62*	***504.89***	
RN Shared Services	*15 minutes*	*1*	*4.00*	*12.45*	***49.80***	
RN Supervisory Visit	*1 visit*	*8*	*8.11*	*72.18*	***4683.04***	
LPN Shared Services	*15 minutes*	*1*	*4.00*	*4.00*	***16.00***	
RN Services	*15 minutes*	*1*	*4.00*	*18.06*	***72.24***	
LPN Services	*15 minutes*	*11*	*14548.90*	*11.71*	***1874043.81***	
CNA/HHA-CMT	*15 minutes*	*1*	*4.00*	*6.19*	***24.76***	
CNA/HHA-CMT Shared	*15 minutes*	*1*	*4.00*	*4.27*	***17.08***	
Principal Physician's Participation in the Plan of Care Meeting Total:						***1607.30***
Principal Physician's Participation in the Plan of Care Meeting	*1 meeting*	*26*	*1.51*	*40.94*	***1607.30***	

GRAND TOTAL:		***3488513.30***
Total Estimated Unduplicated Participants:		***220***
Factor D (Divide total by number of participants):		***15856.88***
Average Length of Stay on the Waiver:	*343*	

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*
Case Management Total:						***1640936.81***
Waiver Enrollment Administration	*1 month*	*21*	*2.17*	*1200.86*	***54723.19***	
Second & Any Subsequent Month	*1 month*	*212*	*12.44*	*600.42*	***1583475.66***	
First Month Waiver Enrollment Administration	*1 month*	*2*	*1.14*	*1200.86*	***2737.96***	
Medical Day Care Total:						***18001.88***
Medical Day Care	*1 day*	*1*	*169.00*	*106.52*	***18001.88***	
Private duty nursing service Total:						***1938546.07***
Nurse Assessment	*1 assessment*	*1*	*3.41*	*152.44*	***519.82***	
RN Shared Services	*15 minutes*	*1*	*4.00*	*12.52*	***50.08***	
RN Supervisory Visit	*1 visit*	*8*	*8.32*	*72.57*	***4830.26***	
LPN Shared Services	*15 minutes*	*1*	*4.00*	*8.12*	***32.48***	
RN Services	*15 minutes*	*1*	*4.00*	*18.16*	***72.64***	
LPN Services	*15 minutes*	*11*	*14930.09*	*11.77*	***1932998.75***	
CNA/HHA-CMT	*15 minutes*	*1*	*4.00*	*6.22*	***24.88***	
CNA/HHA-CMT Shared	*15 minutes*	*1*	*4.00*	*4.29*	***17.16***	
Principal Physician's Participation in the Plan of Care Meeting Total:						***1658.75***
Principal Physician's Participation in the Plan of Care Meeting	*1 meeting*	*26*	*1.55*	*41.16*	***1658.75***	

GRAND TOTAL:		***3599143.51***
Total Estimated Unduplicated Participants:		***220***
Factor D (Divide total by number of participants):		***16359.74***
Average Length of Stay on the Waiver:	*343*	

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*
Case Management Total:						***1692111.16***
Waiver Enrollment Administration	*1 month*	*21*	*2.22*	*1207.34*	***56286.19***	
Second & Any Subsequent Month	*1 month*	*212*	*12.76*	*603.67*	***1632999.79***	
First Month Waiver Enrollment Administration	*1 month*	*2*	*1.17*	*1207.34*	***2825.18***	
Medical Day Care Total:						***18572.62***
Medical Day Care	*1 day*	*1*	*173.43*	*107.09*	***18572.62***	
Private duty nursing service Total:						***1999473.61***
Nurse Assessment	*15 minutes*	*1*	*3.50*	*153.27*	***536.44***	
RN Shared Services	*15 minutes*	*1*	*4.00*	*12.59*	***50.36***	
RN Supervisory Visit	*1 visit*	*8*	*8.54*	*72.96*	***4984.63***	
LPN Shared Services	*15 minutes*	*1*	*4.00*	*8.16*	***32.64***	
RN Services	*15 minutes*	*1*	*4.00*	*18.26*	***73.04***	
LPN Services	*15 minutes*	*11*	*15321.25*	*11.83*	***1993754.26***	
CNA/HHA-CMT	*15 minutes*	*1*	*4.00*	*6.25*	***25.00***	
CNA/HHA-CMT Shared	*15 minutes*	*1*	*4.00*	*4.31*	***17.24***	
Principal Physician's Participation in the Plan of Care Meeting Total:						***1710.65***
Principal Physician's Participation in the Plan of Care Meeting	*1 meeting*	*26*	*1.59*	*41.38*	***1710.65***	

GRAND TOTAL:		***3711868.04***
Total Estimated Unduplicated Participants:		***220***
Factor D (Divide total by number of participants):		***16872.13***
Average Length of Stay on the Waiver:	*343*	

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*
Case Management Total:						***1746571.10***
Waiver Enrollment Administration	*1 month*	*21*	*2.28*	*1213.86*	***58119.62***	
Second & Any Subsequent Month	*1 month*	*212*	*13.10*	*606.92*	***1685538.22***	
First Month Waiver Enrollment Administration	*1 month*	*2*	*1.20*	*1213.86*	***2913.26***	
Medical Day Care Total:						***19162.03***
Medical Day Care	*1 day*	*1*	*177.97*	*107.67*	***19162.03***	
Private duty nursing service Total:						***2063992.74***
Nurse Assessment	*15 minutes*	*1*	*3.60*	*154.09*	***554.72***	
RN Shared Services	*15 minutes*	*1*	*4.00*	*12.66*	***50.64***	
RN Supervisory Visit	*1 visit*	*8*	*8.76*	*73.36*	***5141.07***	
LPN Shared Services	*15 minutes*	*1*	*4.00*	*8.21*	***32.84***	
RN Services	*15 minutes*	*1*	*4.00*	*18.36*	***73.44***	
LPN Services	*15 minutes*	*11*	*15722.67*	*11.90*	***2058097.50***	
CNA/HHA-CMT	*15 minutes*	*1*	*4.00*	*6.29*	***25.16***	
CNA/HHA-CMT Shared	*15 minutes*	*1*	*4.00*	*4.34*	***17.36***	
Principal Physician's Participation in the Plan of Care Meeting Total:						***1774.25***
Principal Physician's Participation in the Plan of Care Meeting	*1 meeting*	*26*	*1.64*	*41.61*	***1774.25***	

GRAND TOTAL:		***3831500.12***
Total Estimated Unduplicated Participants:		***220***
Factor D (Divide total by number of participants):		***17415.91***
Average Length of Stay on the Waiver:	*343*	